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***Prescribing and Proscribing: The
Public-Private Relationship in the
Treatment of Drug Addiction in
England, 1970-99***

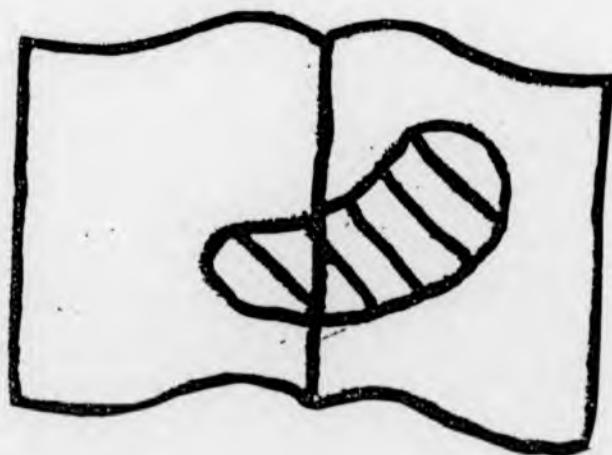
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Thesis submitted for PhD degree

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Abstract

People dependent on illicit drugs have prompted a range of policy responses. In England, the medical profession has played a major role in this area since the nineteenth century, prescribing drugs such as heroin and morphine to those addicts considered unable to give up using them. In the late 1960s, amid important regulatory changes, drug dependent patients were transferred out of primary care and into new National Health Service 'Clinics' based in hospitals.

This thesis starts just after these major changes and traces the relationship between doctors treating drug users within the NHS – initially inside the Clinics, and later also in general practice – and doctors prescribing privately and paid by fee. A debate about appropriate prescribing to drug users is traced from its origins within the Clinics in the 1970s to include the role of doctors working outside both privately and in the NHS in the 1980s and '90s. Conflict emerged between these doctors and manifested itself in regulatory activities and in the general and medical media. The role of formal and informal regulation in these battles and the involvement of the media are particular foci of the research which considers the parts played by the Home Office Drugs Inspectorate, the General Medical Council, and the production of clinical guidelines, as well as the formation of professional interest groups representing different doctors.

The study used oral history materials (53 interviews were carried out with key individuals and private prescribers), archival research, published reports, the medical and general press and academic journals, as well as broadcast radio and television programmes.

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To my parents
Gerald and Valerie

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Chapter 1: Introduction

Introduction

People dependent on illicit drugs have prompted a range of policy responses. In the United States, drug addicts were criminalised and doctors excluded from treating their addictions from the 1920s. By contrast, the English medical profession has played a major role in this area since the nineteenth century. In 1926 drug addiction was defined as an illness and therefore the responsibility of doctors¹ with official British policy allowing the prescription of substitute drugs to addicts in non-increasing doses if they were unable to give up using drugs. This approach, which became known as the 'British System', maintained the drug user's addiction but relieved their difficulties in obtaining a supply.

Doctors in England continued to prescribe to their small number of mainly opiate dependent patients until the 1960s when a government enquiry located such substitute prescribing as the source of an illicit trade increasing the number of addicts. Restrictions on prescribing substitute drugs were introduced and conflict re-emerged within the medical profession regarding appropriate treatment. Since this time, a major fault line of this debate has been between practitioners practising privately and on the National Health Service (NHS).

Treatment norms for illicit drugs in the NHS changed between 1970 and 1999 in terms of the drugs prescribed, the route of administration and the goals of treatment. Private practitioners' continued willingness to prescribe injectable opiates and methadone came under critical scrutiny² and the interface between public and private treatment became more antagonistic than in other areas of health care.

Areas of conflict between public and private prescribers and related agencies

Opiates were at the heart of the debates over treatment in the last century. It was these drugs for which substitute therapy was provided by the medical profession, whether in the form of the original drug of addiction, such as morphine or heroin, or more recently, a replacement such as methadone. Some substitute prescribing was also provided for amphetamine and latterly benzodiazepine dependence. It was substitute therapy that was the focus of the greatest

¹ Departmental Committee on Morphine and Heroin Addiction, *Report* [Rolleston Report] (London: HMSO, 1926) p.11.

² eg J. Strang, J. Sheridan and N. Barber, 'Prescribing injectable and oral methadone to opiate addicts: results of the 1995 national postal survey of community pharmacies in England and Wales', *British Medical Journal*, 313 (1996), 270-2.

controversy in the last 30 years. Private facilities that did not prescribe substitute drugs have generally escaped the censure directed at prescribers.

For many years NHS doctors accused private practitioners of prescribing substitute drugs in over large quantities, with the risk of causing overdose in their patients and of those in receipt of prescriptions selling any surplus on the black market and so spreading addiction³. These doctors were also portrayed as entering the field without adequate training or experience, of failing to check their patients' compliance with treatment and of being motivated primarily by money.⁴ It has also been argued that because most dependent drug users in treatment were unemployed, they must be selling some of their prescribed drugs on the black market in order to pay their medical bills.

In turn, private doctors accused the NHS of being overly bureaucratic, of caring more about controlling the supply of prescribed drugs than about the health of their patients, and of hypocrisy.⁵ These arguments were aired in a number of arenas including regulatory hearings before the General Medical Council and the Home Office's Drugs Tribunals, the medical press and the general media.^{6,7} Media coverage was in turn used to inform the regulatory process.

Aims of the Research

The period started after some major changes to doctors' clinical autonomy in the late 1960s, along with the establishment of specialist NHS treatment centres, and ended just before an intensive period of regulatory intervention against private prescribers. In 2000 and 2001 a flurry of GMC cases disciplined and struck off the medical register a number of private prescribers. In the intervening years there were many challenges to private doctors and the way they prescribed drugs to addict patients.

³ eg. Advisory Council on the Misuse of Drugs, *Treatment and Rehabilitation*, DHSS (London: HMSO, 1982).

⁴ Anonymous, 'Doctor Death', *The Listener* (29th July 1982), 22.

⁵ eg. A. Dally, *A Doctor's Story* (London, Macmillan, 1990) pp.57-98.

⁶ T. Bewley, and A. H. Ghodse, 'Unacceptable face of private practice: prescription of controlled drugs to addicts', *British Medical Journal*, 286 (1983), 1876-77.

⁷ 'File on Four', BBC Radio Four (1997).

Private prescribing was virtually unknown outside the south east of England and has almost entirely been concentrated in London. Since the position of private prescribers in this study was particular to England, and there were considerable differences in services and prescribing practices in both Scotland and Northern Ireland, this thesis usually refers to 'England'. 'Britain' is used where policies or conditions also related to Wales and Scotland and refers to the 'United Kingdom' when also including Northern Ireland. The English situation was not easily comparable with overseas countries so there was little scope for an international comparative perspective.

This study has taken both a narrow and a broad focus. It has aimed to explain the causes and development of the conflict between and around NHS and private practitioners in the treatment of drug misuse and also to illuminate wider issues. The research was pursued on two axes, chronologically, through historical periodisation since the 1970s, and through cross cutting themes. Its aims were:

1. To research the recent historical and current relationships between the public and private treatment of addiction since the major changes in drug treatment policy of the 1960s, including the issues and implications of the regulation of the medical profession, the roles of professional and organizational issues, and of the relationship between research and policy.
2. To contribute to current policy debates on the treatment of addiction a research led analysis based on longer term perspectives.
3. To consider contemporary historical methodologies and techniques in both archival and oral history approaches.

Methodology

The study of the distant past has tended to offer the historian a simple choice of sources limited by what little has survived. By contrast, the contemporary historian risks being overwhelmed by the range and detail of available material. Much has been accessible for study, although there were certain locked doors, such as some government material and most patient records. Aside from the practical problems of selection and comprehensiveness that this abundance could present, it has offered the potential for the historian to produce a detailed and vivid picture of the recent past.

Several contemporary historians have offered their advice on the benefits and pitfalls of the various sources available for studying the twentieth century: oral history, government documents, personal papers, audio-visual materials, biography, journals, the press, and policy reports, all of which were used in this study. Certain principles applied across all sources: the need to be aware of censorship, either self-imposed or from outside; judging the degree of the material's reliability; the extent to

which the creator or selector of the source was self-consciously aware of its place in history; the context in which the source was created and its intended purpose.^{8,9,10}

A number of caveats have been expressed regarding the use of central government archives. Such archives were not drawn up by a historian but by archivists and have formed an 'organic whole' where papers related to each other.¹¹ Two processes therefore needed to be considered: how and why the document was originally produced, and then the criteria behind its preservation and availability in the archives. However, this did not always turn out to be the case. With the Department of Health's archives, documents were selected by the civil servants who generated them, and the content of files was often unknown to the record officers.

Oral history has answered two of the contemporary historian's needs: the ability to ask questions about the past which the historian has so far been unable to understand from other sources, and the possibility of exploring areas of interest to the present which were not thought to be of importance or went unrecorded at the time.¹² Paul Thompson has been at the vanguard of the campaign to develop 'a more socially conscious and democratic history' by using oral history to represent the lives of those who were often undocumented.¹³

Anthony Seldon has also recommended its use for studying elites. This has generally involved 'purposive' sampling where interviewees were selected 'because of who they are or what they did'.¹⁴ In drawing up the sample, however, Seldon referred to the variation in reliability across different occupational groups. He concluded that politicians were the least satisfactory of interviewees because of their 'pathological difficulty in distinguishing the truth, so set have their minds become by long experience of partisan thought.' By contrast, civil servants were among the best because of their dispassionate and careful observation of events.¹⁵

⁸ M. James, 'Historical research methods' in K. McConway (ed.), *Studying Health and Disease* (London: Open University Press, 1994) pp.36-48.

⁹ N. Cox, 'National British archives: public records' in B. Brivati, J. Buxton and A. Seldon (eds.), *The Contemporary British History Handbook* (Manchester and New York: Manchester University Press, 1996) pp.253-271.

¹⁰ M. Scammell, 'Television and contemporary history' in B. Brivati, J. Buxton and A. Seldon (eds.), *The Contemporary British History Handbook* (Manchester and New York: Manchester University Press, 1996) pp.408-422.

¹¹ N. Cox, (1996) *op. cit.*, p.254.

¹² A. Seldon, 'Elite interviews' in B. Brivati, J. Buxton and A. Seldon, (1996), *op. cit.*, pp.353-365.

¹³ P. Thompson, *The Voice of the Past. Oral History* (Oxford: Oxford University Press, first edition 1978, this edition 1988) p.viii.

¹⁴ A. Seldon, (1996) *op. cit.*, p.353.

¹⁵ *Ibid.* p.360.

Following this advice, and the fact that politicians had very little direct involvement in the events considered, no politicians were interviewed for the project; as Seldon predicted, interviews with civil servants proved very helpful, with detailed recall of events which usually proved accurate when they could be cross-checked with other sources.

The importance of establishing trust with interviewees has also been discussed,¹⁶ especially when asking potentially intrusive questions of strangers. Here, the techniques for establishing trust developed and explored in the sociological literature were helpful. This research was particularly sensitive to pursue, especially among private doctors, who feared interest in their working practices because of the unwelcome attentions several had received from the media and from regulatory bodies. Furthermore, the polarised nature of the debate made many doctors suspicious that the research was starting from a partisan viewpoint.

William Foote Whyte's classic study of an Italian slum in North America showed the essential role played by a 'sponsor', who, trusted by the subjects, vouched for the researcher.¹⁷ In the research on private doctors, this occurred not with a single sponsor, but with a succession. Trust established with one interviewee led to their contacting another potential interviewee, who, once his trust was gained, referred the researcher to another and so on. This was similar to 'snowball sampling', a technique used to gain access to hidden populations, but differed in that most of the interviewees' names were known in advance to the researcher. Trust established during the interview was probably based on all the signs and signals that denoted the researcher was engaged in serious academic study rather than sensationalist reporting and had spent a number of years in the field.

As a school of public health, London School of Hygiene and Tropical Medicine's neutral position in the debate also helped to gain the confidence of interviewees that the research was not partisan, in a way that would not have been the case had the research been carried out from a drugs research institution. Finally, the reputation of the author's supervisor was also helpful in interviewing doctors and patients. In some cases interviewees knew of Virginia Berridge as a highly respected historian who was not allied to particular policy lines. In others, certain interviewees had misinterpreted her work on nineteenth century opium use as advocating drug legalisation or law reform in the present day. Both these views, accurate and otherwise, disposed several wary interviewees favourably towards the research.

¹⁶ *Ibid.* p.355.

¹⁷ W. F. Whyte, *Street Corner Society, The Social Structure of an Italian Slum* (Chicago: University of Chicago Press, 1955) pp.279-373.

Once trust was established, Seldon suggested that in turn it could bring difficulties: as a personal relationship developed during the course of an interview it could be difficult being critical of someone who had been kind and hospitable. Presumably the opposite could apply too, but was not considered. He also warned of the danger, particularly for younger researchers, of being overly deferential to senior people. The importance of being dispassionate was emphasised. Seldon noted the advantages of the animate nature of oral history, with interviewees offering further documents of their own or suggesting new areas of inquiry.¹⁸ Both of these happened, with six interviewees providing papers from government and professional organisations and one lending a video tape of television programmes from the period.

The reliability or otherwise of memory has received considerable attention with relation to oral history. Its selectivity and loss of accuracy over time have been noted, as well as the common instance of similar events becoming merged together and the difficulty of extracting fact from opinion.¹⁹ Given this variable reliability, Paul Thompson and Robert Perks have recommended that evidence should be evaluated in terms of internal consistency of a particular interview and in comparison with other sources. Indeed the very subjectivity of oral history interviews has been put forward as an asset, providing opinion and a personal perspective on events, processes and personalities.²⁰

Age was a problem with some interviewees who were in their eighties and could not remember some events well enough, which they found frustrating and depressing. However, other elderly interviewees, thinking that they had poor memories, were gratified when questions prompted recollections they had long since thought they had forgotten. An interviewee's lifestyle could also affect their memory. Although the exact effects of long term illicit opiate use (often combined with other illicit drugs and adulterants) on already formed memories are unknown, being intoxicated tends to prevent clear memories from forming at the time. One patient interviewed said that his chronology of events was rather hazy because he was 'quite out of it' for a lot of the 1980s.²¹

The fact that time intervened between events under discussion and the present also brought up the influence of hindsight, and how views and events have been subsequently rearranged by the

¹⁸ A. Seldon, (1996) *op. cit.*, pp.353-359.

¹⁹ P. Thompson and R. Perks, *An Introduction to the Use of Oral History in the History of Medicine*, (London: National Life Story Collection, 1993) pp.12-13.

²⁰ *Ibid.* p.13.

²¹ Patient 001, Interview by Sarah Mars, (2001).

interviewee to suit the present.²² This was borne in mind but it applied equally to any retrospective source.

During the oral history research, the author began to consider how purposive sampling and the interview process constructed the identity of the interviewees. With elite history, a doctor or civil servant was chosen for interview on the grounds of his or her profession and often, achievements. This role was usually one that they had chosen themselves and how they would willingly identify themselves. Other interviewees were chosen because they were drug users and had been or still were patients, an identity which may have involved less positive choices and, being stigmatised, was not necessarily the way in which they would identify themselves to others or even to themselves.

In order to counteract this labelling, during one of the interviews with a drug user, instead of asking about their drug using history, the first questions were about her life and occupations, hoping to see where drug use would fit into this picture, rather than imposing it from the outset. The interviewee was also asked how she would introduce herself at a party to see how she would describe herself in a non-medical context. The results were interesting, but it was not certain whether this approach actually altered the outcome. Further future research on the differences between identities imposed and those taken willingly and their effect on interview data could be useful.

Oral testimony has often formed part of television and radio broadcasts, about which many of the same caveats have been expressed and new ones added. Both television and radio have played a part in the debate around the private treatment of drug addiction. As 'historical actors' in the field of medicine and health, television and film may have influenced directly government policy or indirectly through raising public concern. Kelly Loughlin stated that the 'medico-scientific elite' was unusual in the level of influence it has enjoyed in the media and its ability to reply to criticism made through the media.

The author also considered what could be termed the 'analytical distance' from the research subject. If there were no theoretical distance taken by the researcher, so that categories and definitions expressed by those involved in the debate were accepted at face value, there would be a number of difficulties. First, different parties expressed contradicting values and beliefs that could not be reconciled. Second, the lack of any distance would prevent any deeper theoretical understanding that could be used to make comparisons across time and space.

²² A. Seldon, (1996) *op. cit.*, p.356.

Taking an intermediate level of analytical distance would enable the use of commonplace concepts such as 'profession', 'medicine', 'regulation' and 'patient'. These terms have been useful in relating empirical research to theoretical knowledge, and transferring concepts between different contexts. They are also easily recognisable and can be related to everyday experience without difficulty and so relatively accessible to the reader. A weakness was that they were historically situated and meant different things at different times. A single term could cloak important changes in both substance and understanding without the user realising.

At a third, higher level of analytical distance, every category and concept used would first be open to question and re-definition. Such an approach might ask 'What is a doctor?' A 'doctor' might be defined as someone who has invested in a long period of study and been admitted to an exclusive occupational group allowing him/her to practice technical skills on live human bodies and to demand certain financial rewards. The value of such an approach would be to cut away familiarities and presumptions, letting us see things afresh. However, any explanation, however abstract, would require some underlying model in order to communicate to the reader, and so risked replacing one set of assumptions with another. Further, it would have greatly reduced the quantity of empirical data that could be considered in a given time.

The approach of this study was generally to take an intermediate level of analytical distance. A certain degree of acceptance of everyday concepts has been necessary in order to make progress in the empirical research beyond theoretical abstractions, using concepts that seemed useful, while questioning others, such as 'expertise' and 'private', that have emerged from the data as being particularly problematic.

Study Design

The study used several archival collections, including the papers of Dr Ann Dally, the highest profile private prescriber of the 1980s, which she had deposited at the Wellcome Library for the History and Understanding of Medicine and included those of the Association of Independent Doctors in Addiction which she founded. Under 'open government' the Department of Health granted access to committee papers and correspondence on the 1984 and 1999 'good practice' guidelines on the treatment of drug misuse. Committee documents and transcripts of hearings before the disciplinary committee of the General Medical Council were also studied in detail. Informal archives in the possession of interviewees were loaned for the Association of Independent Prescribers, the London Consultants' Group, the Department of Health's 'good

practice' guidelines working groups, and a Home Office Drugs Tribunal. Published sources such as reports of the Advisory Council on the Misuse of Drugs, clinical guidelines, the medical and general press and academic journals were used, as well as broadcast radio and television programmes.

Fifty-three oral interviews were carried out with 45 individuals, including 28 doctors practising privately and in the NHS (see Appendix A for details), two nurses, two senior civil servants from the Department of Health, three senior or middle-ranking civil servants from the Home Office, five members of the Advisory Council on the Misuse of Drugs (a partially overlapping category), four patients, one researcher, three senior voluntary sector workers, a policeman and an administrative police employee. In addition numerous informal discussions with existing contacts took place.

With the private doctors, the aim was to interview as many as possible. Prior to the start of the project, the author had held some concerns regarding the willingness of this group to be interviewed. However, she succeeded in gaining the confidence of nearly all the private prescribers with significant involvement in addiction in the years 2000-2003, and a number who had retired. This generated the most complete dataset of this group produced to date. The other interviewees were sampled purposively for their individual involvement in developments of the period, while also trying to gain good representation of the relevant agencies and historical periods.

All interviewees were given an information sheet outlining the study plans and the background of Sarah Mars and Virginia Berridge. They also signed a consent form in line with National Sound Archive and LSHTM History Group practice (see Appendix C) offering a range of conditions for attribution which seemed to give them confidence to speak freely without fear of misquotation. Most of the interviews were audio taped, but some interviewees declined to be recorded and contemporaneous handwritten notes were made instead with their permission.

Analysis

The study used the sources in a 'sceptical empiricist' way, where each piece of evidence was assessed with the overall analysis in mind. The use of many different types of sources enabled triangulation of the data. The methodology was an inductive one, where the process of analysis continued throughout the evidence gathering. Ongoing data collection and analysis in turn guided the selection of sources.

In considering all the source material, questions were asked about internal consistency, agreement or otherwise with other sources, as well as the biases discussed above. The themes that have concerned those studying policy were of interest, including relations between the centre and periphery, relations between the state and professionals, relations within professions, involvement of lay people and non-medical individuals in the policy process, processes of policy development and implementation and the relationship between research evidence and policy. Concepts developed from the policy community literature and from organizational theories such as Cultural Theory (also known as 'Grid Group Theory') suggested that forms of groups and networks could be significant in explaining doctors' different approaches and strategies. These are discussed in greater detail in the reviews of the literature below.

Obstacles Encountered During the Research

Access to Department of Health documents was covered by the 'Thirty Year Rule', but was granted under 'open government' legislation. Record officers at the Department of Health's archive in Nelson, Lancashire, were helpful but files had been named inaccurately and inconsistently by the civil servants sending them to the archive and were therefore difficult to identify and retrieve. Furthermore, many important committee papers were missing from these files. Fortunately this was partly overcome by the generosity of members of the 1984 and 1999 working parties responsible for producing good practice guidelines who loaned the author their committee papers and correspondence, revealing a much fuller picture of events.

Following legal advice, the Home Office was unwilling to disclose documents relating to their Misuse of Drugs Act Tribunals, but granted several extensive interviews. One doctor who had been subject to a tribunal passed copies of its entire proceedings to the author, but since this was the only accessible example of the tribunals, and had a number of unusual features, limited conclusions could be drawn about the process. Furthermore, had access been granted to Home Office documents, it seems likely that this might also have proved frustrating as many of the documents seem to have been destroyed or never archived. The GMC provided full transcripts of their disciplinary proceedings on request, but repeated attempts to seek interviews came to nothing.

Papers of the London Consultants Group (LCG) were sought through a number of routes throughout the project, but their existence was repeatedly denied. Eventually some were found to be in the possession of a practising consultant psychiatrist member, and after sharing a couple of documents, he sought the Group's permission before divulging any more. The LCG would not allow my attendance at its meeting to explain the purpose of the research and, despite the apparent

support of the member in possession of the papers, the group refused the request. Oral history interviews and the small number of accessed papers were therefore used to provide as full a picture as possible of the role of the LCG. This frustrating experience was, however, illuminating of the nature of the LCG: it had succeeded in controlling information which dated back to 1968, across generations, despite the fact that it was not centrally held and its existence possibly not even known among other members before the meeting. The Group's strong identity and sense of solidarity meant that an individual member did not feel able to act autonomously, but needed corporate permission to proceed, and its secrecy showed a strong boundary to the outside world.

Problems were also encountered in trying to quantify the number of private practitioners working during the period and how many patients they treated. Most national figures relating to doctors treating patients for addiction between 1970 and 1997 were derived from the Addicts Index, held by the Home Office. (The Index was closed in 1997). Doctors would complete forms giving their own name, that of the patient, the drugs to which he/she was addicted, and whether they worked in a DDU, general practice or prison. Unfortunately the forms did not distinguish whether the doctor was practising privately or for the NHS.

It was hoped that by compiling a list of all private doctors working during the period through documentary and interview research, their names could be matched to the dated returns to the Addicts Index to determine which doctors were treating patients at different periods and the number of patients they had treated. However, searching the returns would have been too great a task for this, and, in spite of the enthusiasm of one relatively junior member of staff at the Home Office, it is uncertain whether the Home Office would have allowed it on grounds of confidentiality due to the presence of patients' names on the returns. The Medical Register might have offered an alternative avenue, but it tended not to give details of a doctor's private practice in drug treatment. A private doctor interviewed explained that not publicising his services allowed him to control demand and avoid being inundated with these patients.²³

Reviews of the Literature

No one has written a history of this topic, and in fact there has been little research carried out on English private medicine in general; these literature reviews have not therefore included any 'histories of private prescribing' but concentrate on relevant background areas and useful theoretical approaches. Publications which could be said to constitute the public-private debate itself were considered as such in the main body of the primary research. The existing literature on

²³ M. Johnson, Interview by Sarah Mars, (2000).

the history of drug treatment services and policies has been given a chapter of its own after these reviews to illustrate the background developments to the study (see Chapter 2). The research project crossed several areas of study, and these are reflected in the reviews. The literature on public-private mix in health care was an obvious starting point, and from there, some historical context on the history of the English medical profession was explored to provide a wider context to the debate. The concepts of addiction and dependence were to be central to discussions around prescribing to drug users and so were also considered. Professions and their regulatory systems have been the subject of considerable attention, particularly from sociologists and economists, as well as historians; their work has been reviewed, along with the less extensive literature on external systems of inspection. As a history of policy, this project considered literature on the 'policy community', as a useful conceptual approach, and finally, Cultural Theory (or 'Grid Group Theory') offered potential for understanding the structures, values and strategies of some of the organisations studied.

Public and private health care mix

Although the debate between private and NHS doctors has been presented, particularly by those exclusively in the NHS, as a clash between two sectors, many of the doctors who have practised in the private sector worked concurrently in the NHS. Furthermore, this private practice was untypical of the English private sector for the following reasons: it was extremely unusual for NHS consultant psychiatrists treating drug users to take on private patients; most private practice was undertaken either by consultants who had left the public sector or by general practitioners. Those criticising private practice have claimed a further difference from other areas of private health care was that many of the patients did not have a regular income and funded treatment from criminal sources.²⁴ It has not been possible to gather quantifiable data on patients' sources of income during this study, but interview data has suggested a range of methods of paying fees, including health insurance,²⁵ social security,²⁶ or payment by family members²⁷ as well as the sale of prescribed drugs.²⁸ Data from GMC hearings also suggested that non-payment of fees was a common problem for doctors in this area.

Much of this private treatment was long term, which was also unusual as was the relationship between supply and demand. Some doctors working in this area sought to deter patients from

²⁴ eg ACMD, (1982) *op. cit.*, p.54.

²⁵ C. Brewer, Interview by Sarah Mars, (2000).

²⁶ M. Johnson, (2000) *op. cit.*

²⁷ A. Garfoot, Interview by Sarah Mars, (2000).

²⁸ Patient 002, Interview by Sarah Mars, (2002).

seeking their help rather than openly advertising their services for fear of being overwhelmed by demand and also to select desirable patients. A form of treatment for drug users more typical of the wider private sector has been provided by in-patient psychiatric hospitals such as the Priory Group, but in view of their abstinence orientated approach and lack of long term substitute prescribing,²⁹ they were not involved in this public-private controversy.

For these reasons, the existing literature on public-private mix has had limited relevance and little has been written specifically on the relations between private and NHS doctors in the drugs field; what could be considered 'secondary sources', constitute part of the debate itself and so are generally treated as primary sources. Private primary care as a whole was extremely poorly documented and private practice by consultants was also largely uncharted, with the most comprehensive research relating to surgical practice.³⁰ Laing and Buisson produced an annual overview of the private sector dating back to the 1988 but have not been able to overcome these shortfalls in the data.³¹ More theoretical work has been carried out on fee-paying private practice in developing countries³² but has been difficult to apply to this unusual area of English private practice.

History of the medical profession in England

Medical practice in England has dated back many centuries, but it was in 1518 that doctors in London gained a royal charter for their Colleges of Physicians, set up to control medical practice in and around the City of London through a system of licensing. These were the beginnings of medicine's organisation as a profession with attendant regulation. In the nineteenth century Britain's doctors arranged themselves into bodies to represent themselves nationally in the form of the British Medical Association, and with state support, to regulate themselves through the General Medical Council (1858).

Histories of the medical profession since the National Health Service (1948), for which most of the doctors in England work, have concentrated particularly on its relations with the state. Important work has been carried out by Rudolf Klein, Chris Ham and Charles Webster.^{33,34,35}

²⁹ D. Curson, 'Private treatment of alcohol and drug problems in Britain', *British Journal of Addiction*, 86 (1991), 9-11.

³⁰ J. Yates, *Private Eye, Heart and Hip. Surgical consultants, the National Health Service, and Private Medicine* (Edinburgh: Churchill Livingstone, 1995).

³¹ eg Laing and Buisson, *Review of Private Healthcare and Long Term Care* (London: Laing and Buisson, 1999).

³² eg S. Bennett, B. McPake and A. Mills, *Private Providers in developing Countries: Serving the Public Interest?* (Atlantic Highlands, NJ: Zed Books, 1997).

³³ eg R. Klein, *The New Politics of the National Health Service* (first published 1983, London and New York: Longman; fourth edition, Harlow: Prentice Hall, 2001).

Changes in the status and power of the medical profession both as a whole and within its constituent parts have been observed over the last half-century. The establishment of the NHS changed the relationship between hospital doctors and GPs as their division of labour, roles and status altered. Frank Honigsbaum explored the development of this separatism and the tensions that arose before and after the NHS was established. The negotiated settlement between government and the profession gave voluntary hospital consultants and leaders of the profession security, privilege and high remuneration while permitting the continuation of private practice. It also worsened the long-running rift between the consultants and GPs.^{36,37}

Webster has shown how GPs' status lagged behind hospital doctors for many years under the NHS, until change started with the 1966 new contract that encouraged improvements in practice premises, continuing education and the employment of ancillary help. This consequently stimulated group practices among GPs and their involvement in health centres.³⁸ General practice continued to enhance its status and its role in medical politics in the 1970s, but failed negotiations with government led to the imposition of a new contract in 1989 bringing enforced changes.³⁹ The development of general practice as an academic subject also helped raise their status.

As a political force, the medical profession held considerable power for most of the twentieth century. Moran and Wood have put the high point of their power and influence as the late 1960s, when the prevailing wisdom in politics was 'that experts knew best'.⁴⁰ This began to change in the 1970s and '80s, with a questioning of the philosophical assumptions of Western medicine, a burgeoning interest in alternative medicines and an increasing sympathy for the ideas of the anti-psychiatry movement that disease was socially constructed.⁴¹

The profession's ability to present a united front, particularly in negotiation with government, has also varied over the last century. Klein, a political scientist, stated that while it appeared to be

³⁶ eg C. Ham, *Health Policy in Britain: The Politics and Organisation of the National Health Service* (Fourth edition, Houndmills: Macmillan, 1999).

³⁷ eg C. Webster, *The National Health Service. A Political History* (Oxford: Oxford University Press, 1998).

³⁸ F. Honigsbaum, *The Division in British Medicine. A History of the Separation of General Practice from Hospital Care 1911-1968* (New York: St Martin's Press, 1979).

³⁹ M. Drury, 'The general practitioner and professional organisations' in I. London, J. Horder and C. Webster (eds.), *General Practice Under the National Health Service, 1948-1997* (London: Clarendon Press, 1998) pp. 205-223.

⁴⁰ C. Webster, (1998) *op. cit.*, p.131.

⁴¹ *Ibid.* p.181.

⁴² M. Moran and B. Wood, *States, Regulation and the Medical Profession* (Buckingham, UK, and Bristol, PA, USA: Open University Press, 1993) p.32.

⁴³ V. Berridge and C. Webster, 'The crisis of welfare, 1974-1990s' in C. Webster (ed.), *Caring for Health: History and Diversity* (Buckingham: Open University Press, 1993) pp. 127-149.

corporatist and disciplined, it was, in fact, made up of individualistic practitioners who were difficult to either control or organise.⁴² He described this as 'syndicalism', with individual doctors holding the power to take strike action themselves without the official central structure of their trade union, the British Medical Association, and splintering off into rival groups.⁴³

The history of private practice, a minority activity in England since the NHS, has received less attention. In mid-1970s London, the influx of Arab patients and their oil wealth led to a massive, if short-lived increase in private practice centred around Harley Street, but this tailed off as the Gulf States established their own hospitals. After Labour's attempts to eliminate private beds from NHS hospitals, the new consultant contract introduced by the Conservative government in 1979 brought a change of direction, removing all practical constraints on the supply of consultant labour to the private sector.⁴⁴ The new emphasis on private medicine from the Thatcher administration continued in the 1980s with a substantial increase in private out-patient attendance and a large expansion of private bed provision in private hospitals.⁴⁵

Addiction and dependence

As treatment of addicted patients through substitute prescribing has been the focus of the debate between private and NHS doctors, the development of the concept of 'addiction' has required some attention. The literature on addiction has not formed a coherent whole and there has been considerable disagreement even to the extent to which addiction has existed. At one extreme John Booth Davies, whose book *The Myth of Addiction*⁴⁶ has proposed that people use drugs because they want to and that any pharmacological properties which produce a compulsion to use have been over-stated.

Historical work, most notably that of Virginia Berridge, has shown the concept of addiction to be both culturally and historically located, its development in relation to both alcohol and drugs reflecting the needs and purposes of professional groups and the processes of scientific 'advance'. Her work on opium use in the nineteenth century showed an absence of the idea of addiction from common understanding at that time. While long term use of opium might have led to the development of a 'habit', this was of relatively little concern. There was no suggestion that the

⁴² R. Klein, *The Politics of the National Health Service* (London and New York: Longman, 1983) pp.89-90.

⁴³ R. Klein, (2001) *op. cit.*, pp.84-88.

⁴⁴ W. Laing, *Going Private. Independent Health Care in London* (London: King's Fund, 1992).

⁴⁵ V. Berridge and C. Webster, (1993) *op. cit.*, pp.127-149.

⁴⁶ J. B. Davies, *The Myth of Addiction* (Amsterdam: Harwood Academic Publishers, 1997).

opium lacked the qualities termed addictive today, rather its context of use and resulting emphases were different.⁴⁷

Historian Roy Porter's research on alcohol showed that various disease models emerged in the eighteenth century and crystallized by the mid-nineteenth century in which drunkenness was seen as requiring medical attention, replacing its conception as a moral or religious weakness. Thomas Trotter, a British doctor writing in 1804, was the first analyst to describe habitual drunkenness as a mental illness, and he likened the effects of spirits to the use of opium, describing them all as narcotics.⁴⁸

Even among those of a more positivist approach who have taken the view that it has a basis in scientifically reproducible experiment, addiction's boundaries have changed considerably over time. The once separate categories of psychological and physical addiction have come together,⁴⁹ and the centrality of withdrawal symptoms and tolerance has been replaced with the sense of compulsion to use a substance. Both 'physical' and 'psychological' aspects were drawn on when the World Health Organization introduced the term 'dependence' in 1964 to replace 'addiction' and 'habituation'.⁵⁰ Bringing together these two ideas under one term widened the range of substances considered to have 'dependence' potential. The merging of psychological and physical aspects arose in part from experimental work showing that dependence developed from learned experiences of substances and anticipation of their effects preceding re-use. Psychology and physiology were therefore seen as intricately entwined.

Influenced by the alcohol literature, the more behavioural definition emphasised an increasing difficulty controlling substance-taking behaviour often reflected in a progressive neglect of alternative activities and an inability to stop regardless of harmful consequences.⁵¹ It meant that a wider range of substances, including cannabis, tobacco and cocaine, could be termed addictive, so extending the scope for medical intervention and upholding the existing legal control system.

⁴⁷ V. Berridge and G. Edwards, *Opium and the People. Opiate Use in Nineteenth Century England* (first published 1981 London: Allen Lane; this edition New Haven and London: Yale University Press, 1987).

⁴⁸ R. Porter, 'Introduction', in T. Trotter (and ed. R. Porter), *An Essay Medical, Philosophical, and Chemical on Drunkenness and Its Effects on the Human Body* (London: Routledge, 1988) pp.ix-xliii.

⁴⁹ T. Stockwell, 'Psychological and social basis of drug dependence: an analysis of drug seeking behaviour in animals and dependence as learned behaviour' in G. Edwards and M. Lader (eds.), *The Nature of Drug Dependence* (Oxford: Oxford University Press, 1990) pp.195-203.

⁵⁰ V. Berridge and S. Mars, 'Glossary of the history of addiction', *Journal of Epidemiology and Community Health*, 58 (2004), 747-750.

⁵¹ G. Edwards and M. Gross, 'Alcohol dependence: provisional description of a clinical syndrome', *British Medical Journal*, i (1976), 1058-1061.

Jim Orford, while advancing a psychological approach to addiction, or what he has termed 'excessive appetites', was nonetheless critical of applying the concept of addiction to drugs, noting that different substances challenged the model. For instance, nicotine produced withdrawal symptoms but not intoxication; cannabis produced a compulsion to use but negligible withdrawal symptoms and caffeine withdrawal brought on symptoms but users seem to have little difficulty stopping. To overcome these difficulties, he recommended that sex and gambling should instead be placed more centrally in the model of addiction.⁵²

As with many areas of behaviour, genetic research has also investigated a hereditary risk from drug problems. While the search for a single 'addictive personality' has produced little, research has moved towards inherited personality traits that may play roles as risk factors in drug and alcohol problems involving complex modelling with environmental factors.⁵³

Professions and Professionalization

The sociological literature which has concerned itself with the development of the professions, what it termed 'professionalization', has also been useful in providing concepts to interpret the structures, values and relationships of the medical profession during the period under study. While not a unified theory, differing approaches have predicted likely changes and the conditions required for these changes. As the term suggests, 'professionalization' refers to a *process* by which an occupation organises itself into a profession.

The role of professions was commented upon by Weber, Durkheim and Marx in the nineteenth century, but it was not until 1928 that Carr-Saunders began a more systematic and detailed approach.⁵⁴ Turner noted that the writings of Durkheim, Weber and Mannheim were criticised for taking an optimistic view of the professions' self-proclaimed altruistic service of others.⁵⁵ Recent commentators such as Friedson have emphasised the economic benefits and power accrued by the professions by their monopoly of certain service provision at the expense of other occupational groups.⁵⁶

⁵² J. Orford, 'Addiction as excessive appetite', *Addiction*, 96 (2001), 15-31.

⁵³ S. A. Ball, 'Personality traits, disorders, and substance abuse' in R. M. Stelmack (ed.), *On The Psychobiology of Personality: Essays in Honor of Marvin Zuckerman* (Oxford: Elsevier, 2004) pp.203-222.

⁵⁴ H. M. Vollmer and D. L. Mills (eds), *Professionalization* (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1966).

⁵⁵ B. Turner, *Medical Power and Social Knowledge* (London: Sage, first published 1987, this edition 1995) pp.129-131.

⁵⁶ E. Friedson, 'The centrality of professionalism to health care' in E. Friedson (ed.), *Professionalism Reborn. Theory, Prophecy and Policy* (Cambridge: Polity Press with Blackwell Publishers, 1994) pp. 184-198.

Up until the 1970s, criticism about the role of professionalism in society was focused on its economic and social advantages and disadvantages with an implicit understanding that this related only to men. Feminist critics changed this, targeting the medical profession as a patriarchal authority controlling subordinate social groups, particularly women,⁵⁷ not only as patients but also where they made up the majority of an occupational group such as nursing.⁵⁸

Johnson considered that by the 1970s the original conditions under which professionalism had developed no longer existed and put forward patronage and state mediation as alternative models for controlling expertise. The model of state mediation could be said to have described the NHS at that time. It provided a guaranteed 'clientele' for the professional, rather than relying on the vagaries of demand from fee-paying clients. This not only increased the level of consumer demand but also limited the effects of consumer choice. The employment of practitioners by the state brought bureaucratic elements to their role and resulted in a general dilemma for the professional in trying to balance administrative and consumer needs.⁵⁹ The apparent absence of a consumer voice in the treatment of drug dependent patients in the NHS may have indicated that, where the client was in a weak social position, this balance may have swung further towards administrative needs.

Harrison and Ahmad considered that since 1975 the medical profession had lost its dominance over other related professions and its autonomy from regulation and evaluation in the United Kingdom. They described a new medical labour process emerging as a 'scientific bureaucratic machine' in which treatments were derived from an externally generated body of research evidence and implemented through bureaucratic rules in the form of clinical guidelines.⁶⁰ These guidelines were in fact the condensation of political criteria dressed up as technical rules and enforced by regulatory agencies.⁶¹ Individual doctors no longer determined treatment decisions for their patients. With this process Harrison and Ahmad charted the rise of the manager within the NHS and the emergence of NHS management as a career path in its own right.

Johnson's later work, influenced by Foucault, rejected the arguments around autonomy and intervention and interpreted the professions in the latter half of the twentieth century as 'socio-technical devices' through which the means and ends of government were articulated. This was achieved by the professions identifying new social problems, constructing the means to solve them

⁵⁷ eg O. Moscucci, *The Science of Woman* (Cambridge: Cambridge University Press, 1993).

⁵⁸ B. Turner, (1995) *op. cit.*, p.130.

⁵⁹ T. J. Johnson, *Professions and Power* (London and Basingstoke: Macmillan Press, 1972) pp.41-61.

⁶⁰ S. Harrison and W. I. U. Ahmad, 'Medical autonomy and the UK state 1975-2025', *Sociology*, 34 (2000), 129-146, p.138.

⁶¹ *Ibid.* p.129-146.

and staffing the organisations created to cope with them.⁶² This image of professions as part of 'governmentality' may sit more comfortably with the involvement of medical professionals within 'policy communities'.

Theoretical Approaches to Medical Regulation

While the 'professionalization' literature has considered the development of occupations, of which self-regulation has constituted an element, this body of work has considered more broadly the different models available for regulating health care and their theoretical underpinnings. It has generally arisen with the aims of identifying and explaining the diverse approaches and assessing the advantages and disadvantages of each.⁶³

Medical regulation, it has been noted, is not a special activity, but part of wider processes of regulation within society, which have included both formal and informal controls ranging from legislation to peer disapproval.⁶⁴ The chief concerns of the literature have depended on the systems that have emerged and the political culture in their countries of origin. For instance, in the United States, where a larger proportion of health care has been private and the political discourse more orientated towards industry and commerce, the literature was particularly preoccupied with the role of the market in regulation.⁶⁵ The British literature, although often cross-national in its comparisons, has tended to address the relationship between the state and the health professions, as the majority of Britain's health care has been provided through the state. However since the 1980s, when the New Right championed market forces in public services, interest in private health care and economic competition have emerged in the regulation literature.⁶⁶

Baggott has identified five conceptual frameworks used by those considering regulatory origins and change.⁶⁷ The first two, 'public interest' and 'private interest' theories have chiefly concerned self-regulation by the professions, and their main contributors have been discussed above (see 'Professionalism and Professionalization'). Private interest theories have taken a cynical view,

⁶² T. Johnson, 'Governmentality and the institutionalization of expertise' in T. Johnson, G. Larkin and M. Saks (eds.), *Health Professions and the State in Europe* (London: Routledge, 1995) p.23.

⁶³ R. Baggott, 'Regulatory politics, health professionals, and the public interest' in J. Allsop and M. Saks (eds.), *Regulating the Health Professions* (London, Thousand Oaks, CA, USA, and New Delhi: Sage Publications, 2002) pp.31-47.

⁶⁴ J. Allsop, 'Regulation and the medical profession' in J. Allsop and M. Saks (2002) *op. cit.*, pp.79-93.

⁶⁵ eg D. Yaggy and W. G. Anlyan (eds.), *Financing Health Care: Competition Versus Regulation. The Papers and Proceedings of the Sixth Private Sector Conference March 23 and 24, 1981*. Duke University (Cambridge, MA, USA: Ballinger Publishing, 1982).

⁶⁶ eg C. Scott, *Public and Private Roles in Health Care Systems*, (Buckingham, UK, and Bristol, PA, USA: Open University Press, 2001).

⁶⁷ R. Baggott, (2002) *op. cit.*, pp.31-47.

seeing regulation as designed and maintained primarily in the interests of the regulated. Baggott has criticised the private interest paradigm by suggesting that professions' codes of ethics have shown that economic self-interest has not always been the primary motivation for regulation. However, other authors have noted the heavier punishments allotted by some professional groups to members transgressing ethical rules governing competition compared with those for harming patients.^{68,69} The opposite position has been put forward in 'public interest theories', sometimes taking at their word the claims of the professions.

A more pluralist version of private interest theories has emerged in the literature typed 'interest group' theories, which have described regulation as the sum of interactions between different 'stakeholders', whether inside a profession or between professional groups and other regulatory bodies. Which groups have been included in the process has depended upon their recognition as legitimate parties at different points in history, with, for instance, greater inclusion of patient groups during the 1980s and '90s than during the 1950s and '60s. A fourth set of commentators has approached regulation as guided by particular ideas and ideologies, and the results of attempts to implement them, while the last group identified by Baggott used the prism of institutional politics, both within and between regulatory institutions. Moran and Wood have incorporated several of these approaches in their work comparing Britain, Germany and the United States. Particularly interesting to this research project has been the division of regulation into formal and informal methods, since informal approaches often seem to have been overlooked in the regulation literature.⁷⁰

Several medical historians, including Roy Porter and Roger Cooter, have considered the development of medical ethics, the constantly changing body of thought used to arbitrate questions of the conduct of medicine and medical research within the profession. They have tended to take the 'interest group' approach mentioned above, seeing medical ethics as the profession's way of elevating itself above mere trade, entitling it to respectful deference from clients and exempting it from various external political and legal controls, while legitimising its rights to self-government and self-policing.^{71,72} Cooter has argued eloquently that although the 'ethical' is conventionally

⁶⁸ eg M. Stacey, *Regulating British Medicine: The General Medical Council* (Chichester: John Wiley and Sons, 1992).

⁶⁹ eg M. Moran, *Governing the Health Care State* (Manchester: Manchester University Press, 1999).

⁷⁰ eg M. Moran and B. Wood, *States, Regulation and the Medical Profession* (Buckingham, UK, and Bristol, PA, USA: Open University Press, 1993).

⁷¹ R. Porter, 'Thomas Gisborne: Physicians, Christians and Gentlemen' in A. Wear, J. Geyer-Kordesch and R. French (eds.) *Doctors and Ethics: The Earlier Historical Setting of Professional Ethics*, (Amsterdam and Atlanta: Rodopi, 1993) pp.252-273.

⁷² R. Cooter, 'The ethical body', in R. Cooter and J. Pickstone (eds.) *Medicine in the Twentieth Century*, (Amsterdam: Harwood Academic Publishers, 2000) pp.457-468.

juxtaposed against the 'political', ethics is simply 'politics by other means'. 'Arbitrating the good and the bad in medicine, (as in society), is necessarily about commanding authority' and has no legitimate claim to the higher morality it has claimed.⁷³

Klein's work, while not primarily theoretical has also considered regulation. His observations on clinical autonomy have produced a useful division between 'collective' and 'individual'. Rather than considering state regulation, in the form of clinical guidelines and protocols, as strengthening state control over the medical profession and weakening medical autonomy,⁷⁴ Klein has seen this, and the process of clinical audit, as the medical profession accepting and participating in the restriction of individual clinicians' autonomy in order to strengthen collective professional autonomy.⁷⁵

These various concepts may be useful in considering the regulation of doctors treating drug users. One part of the process of state regulation has been the part played by the Home Office's Drugs Inspectorate, and it is to the small part of the literature on regulation that has considered the role of government inspectors and inspectorates that this review now turns.

Inspection and Inspectorates

Regulating doctors who were prescribing controlled drugs was not just the work of their peers at the GMC, but also involved direct policing by the state. The Home Office's Drugs Inspectorate, originating in 1916, has been the subject of detailed study in this project. Very little has been written on the Drugs Inspectorate itself and research on other inspectorates and relevant theoretical approaches have therefore been considered here.

In the field of government surveillance, Michel Foucault has made the largest impression on theoretical approaches in the twentieth century. His works on the development of modern medicine and the punishment of criminals have been hugely influential on Western thought.^{76,77} Key has been the notion of 'disciplinary power', which described the use of new "scientific" ideas at the turn of the eighteenth and nineteenth century to define norms, enforcing them through constant surveillance and regulation of time and space in institutions such as asylums, schools, the army, and prisons. These systems controlled individual bodies and internalised pressure to

⁷³ *Ibid.* pp.457-460.

⁷⁴ S. Harrison and W.I.U. Ahmad, (2000) *op. cit.*, pp.129-146.

⁷⁵ R. Klein, *The New Politics of the National Health Service*, (London and New York: Longman, first published 1983, third edition 1995) pp.243-244.

⁷⁶ M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* translated by A. M. Sheridan Smith (first edition, Presses Universitaires de France, 1963; this edition New York: Vintage Books, 1994).

⁷⁷ M. Foucault, *Discipline and Punish: The Birth of the Prison*, translated by A. Sheridan (first edition, Edition Gallimard, 1975; this edition Harmondsworth, England: Penguin Books, 1991).

conform. Those found to be delinquent were dealt with through programmes which both cured and reinforced delinquency, building in their own failure.⁷⁸ Here Foucault was describing processes, rather than interests or institutions, and his work denied personal agency as a historical force.⁷⁹

While Foucault did not necessarily intend his ideas to be taken as a general or consistent theory, or to be applied to other historical contexts,⁸⁰ his acolytes have been more expansive. Worthy of particular attention in this research project is the work of David Armstrong, who adapted Foucault's ideas about the 'Panopticon', Jeremy Bentham's prison design in which all inmates could be observed at all times from a single vantage point, to medical surveillance in the twentieth century. Armstrong described the archetype of a tuberculosis dispensary which acted as a central clearing house of information about sickness and potential sickness in the wider community, mapping the spread of disease and gaining the consent of the well population to undergo policing and surveillance.⁸¹ This model could be valuable in understanding the policing of both doctors and patients in the community by the Home Office Drugs Inspectorate and through the Addicts Index.

Also of potential utility were the more empirical studies of inspectorates. Denis Lawton and Peter Gordon, writing about Her Majesty's Inspectorate of Schools (HMI) described three main elements of inspection: accountability (regarding public expenditure), surveillance for the Secretary of State, and advisory, giving advice to teachers and educational institutions.⁸² Although Lawton and Gordon did not consider a Foucauldian approach, their description of HMI, would not support one. 'The Inspectorate of Schools' surveillance work over teachers acted less to control them and more as a method of advocacy for the professional teaching viewpoint to other civil servants and politicians in government.

Gerald Rhodes looked at several inspectorates within British government, describing seven different types, but concentrated mainly on those inspecting compliance with statutory requirements and those which inspected to maintain or improve standards of performance. He placed the Home Office Drugs Inspectorate into the first category. Rhodes observed that inspectorates often did more than inspecting and drew some potentially relevant conclusions about

⁷⁸ *Ibid.* pp.257-292.

⁷⁹ F. Driver, 'Bodies in space. Foucault's account of disciplinary power' in C. Jones and R. Porter (eds.), *Reassessing Foucault. Power, Medicine and the Body* (London and New York: Routledge, first published 1994, this edition 1998) pp.113-131.

⁸⁰ *Ibid.* pp.116-123.

⁸¹ D. Armstrong, *Political Anatomy of the Body. Medical Knowledge in the Twentieth Century* (Cambridge: Cambridge University Press, 1983) pp.7-18.

⁸² D. Lawton and P. Gordon, *HMI* (London and New York: Routledge and Kegan Paul, 1987).

central government inspectorates which he observed tended to be more specialised and smaller than those of local government. For instance, as well as enforcing legislation among those they inspected, they could develop into professional advisors to ministers and departments, as in the case of the Railway Inspectorate advising the Department of Transport on railway investment plans.⁸³

The Home Office Drugs Inspectorate can also be seen in terms of a bureaucracy – or part of one. Max Weber described the basis of bureaucratic power as technical expertise and knowledge developed through experience in the service. He also saw bureaucracies as having an interest in perpetuating themselves into permanent institutions, rather than serving the ends for which they were originally designed.⁸⁴ It will be interesting to see the extent to which the Home Office Inspectorate matched or deviated from these theoretical models and historical case studies.

Policy communities

The 'policy community' literature has attempted to explain the policy-making processes in government that have developed in the last fifty years. It has examined the relationship between structures inside and outside government that have been involved in decision-making, and has integrated those with an expertise and interest in a particular issue into the process outside government into the picture. The policy community literature has seen four main types of actor making up this relationship: politicians, administrators, lobbyists and 'experts'.

The origins of the policy network literature are in sociology, political science, and social psychology but RAW Rhodes considered there to be general agreement that the term had been used imprecisely and lacked a unified theoretical underpinning. Some uses were simply descriptive and did not constitute a 'theory' in that they made no attempt to explain why things were as they were.⁸⁵

'Sub-government' was a term that originated in the United States. Typically, these clusters of individuals were comprised of members of the House and Senate, members of congressional staffs, bureaucrats, and representatives of private groups and organisations interested in a well-defined policy area.⁸⁶ They considered the non-governmental actors to be an important influence on policy

⁸³ G. Rhodes, *Inspectorates in British Government. Law Enforcement and Standards of Efficiency*, Royal Institute of Public Administration (London: George Allen and Unwin, 1981) p.240.

⁸⁴ M. Weber, *From Max Weber: Essays in Sociology*, translated and edited by H. H. Gerth and C. Wright Mills (New York and Oxford: Oxford University Press, first published 1946, this edition, 1964).

⁸⁵ R. A. W. Rhodes, 'Policy networks a British perspective', *Journal of Theoretical Politics*, 2, 3 (1990), 293-317.

⁸⁶ R. B. Ripley and G. A. Franklin, *Congress, the Bureaucracy and Public Policy* (Pacific Grove, California: Brooks/Cole, first published 1976, this edition, 1987) pp.8-10.

and programme content, but emphasised the variation of sub-governments' influence, particularly dominating the lowest profile policy areas.

Heelo and Wildavsky, in their 1981 book on public expenditure and decision-making in British politics, decided to interpret their subject not in 'the usual terms of relative power and divisions of responsibility' 'but in terms of community and policy'. Here, 'community' referred to the personal relationships between major political and administrative actors, where 'community [was] the cohesive and orienting bond underlying any particular issue'.⁸⁷ However, they put great emphasis on the relationship between politicians and civil servants and gave little space to outsiders, concluding with a plea for the 'government community' to be opened up 'so that outsiders and insiders have more in common – including an understanding of each other's problems'.⁸⁸

For historians using the idea of policy communities, an apparent absence of movement in these models that could take account of change over time has been a problem.⁸⁹ Hay and Richards have tried to rectify this in work arising from the Economic and Social Research Council's Whitehall Programme. The need for this was not merely a theoretical one, but resulted from the changed nature of government itself: they considered that the stability of the past had gone and networks were existing in a state of flux in the new context of heightened mobility of capital, trans-national political interventions, economic decentralisation and privatisation.⁹⁰

Turning to work specific to the health field, Wistow described a 'health service policy community' and, with a broad brush, traced its development since the establishment of the NHS, and the changing balance of power between the medical profession, patients, and administrators and politicians, voluntary services and latterly managers. He related the relative power of parts of the medical profession and their influence on policy to doctors' own system of prestige.⁹¹ This may be of particular relevance to the drugs field where prestige of psychiatry has been notably low, and addiction psychiatry even more so.

⁸⁷ H. Heelo and A. Wildavsky, *The Private Government of Public Money. Community and Policy Inside British Politics* (London: Macmillan, first edition 1974, this edition, 1981) p.lxv.

⁸⁸ *Ibid.* p.389.

⁸⁹ D. von Walden Laing, *HIV/AIDS in Sweden and the United Kingdom Policy Networks, 1982-1992* (Stockholm: Stockholm University, 2001).

⁹⁰ C. Hay and D. Richards, 'The tangled webs of Westminster and Whitehall: the discourse, strategy and practice of networking within the British core executive', *Public Administration*, 78 (2000), 1-28.

⁹¹ G. Wistow, 'The health service policy community. Professionals pre-eminent or under challenge?' in D. Marsh and R. A. W. Rhodes (eds.), *Policy Networks in British Government* (Oxford: Clarendon Press, 1992) pp.51-74.

Historical work carried out on alcohol policy formation, in which some of the same actors were involved as in the drugs field, has clearly mapped a policy community.⁹² Of particular interest to this study is the close relationship between the government and the clinicians and academics based at the Maudsley Hospital in South London, which may also be relevant to drug policies.

Cultural Theory

In trying to understand any conflict or debate, the researcher must seek out the different values that have underlain the positions taken and ask how and why these values have developed. Cultural anthropology has made an important contribution to explaining viewpoints and ideologies in different cultures, initially in distant lands, and more recently, within our own society. An approach that has been increasingly used to understand the way people have interpreted the world and developed values, including in historical work,⁹³ has been Cultural Theory, sometimes known as 'Grid Group Theory'.

Originally developed by Mary Douglas,⁹⁴ Cultural Theory has linked values and beliefs to social relationships, and from these, has explained behaviour. The debate between private prescribers and NHS doctors has involved a range of activities from individuals writing to medical journals to the formation of professional groupings. Douglas and Wildavsky used Cultural Theory to consider the activities and beliefs of environmental pressure groups and how these changed over time to revealing effect,⁹⁵ and it may be useful in examining doctors' organizations and the different strategies they have employed.

Cultural Theory has measured social structure by two dimensions – 'grid' and 'group'. 'Group' measured the extent to which an individual was part of a wider group that met face-to-face and the extent to which that group had boundaries. At the 'zero' position along the 'group' (x) axis, the individual was in a network of his own making which had no recognisable boundaries. (See Figure 1.1) Others, further along from this position, may have belonged to several associations which were clearly bounded so that they could determine who was and who was not a member. At the extreme, an individual's existence may have been completely dominated by group membership.

⁹² Thom, B. *Dealing With Drink. Alcohol and Social Policy From Treatment to Management*, (London and New York: Free Association Books, 1999).

⁹³ eg A. Wildavsky and D. Polisar, 'From individual to system blame: analysis of historical change in the law of torts', *Journal of Policy History*, 1, 129-155.

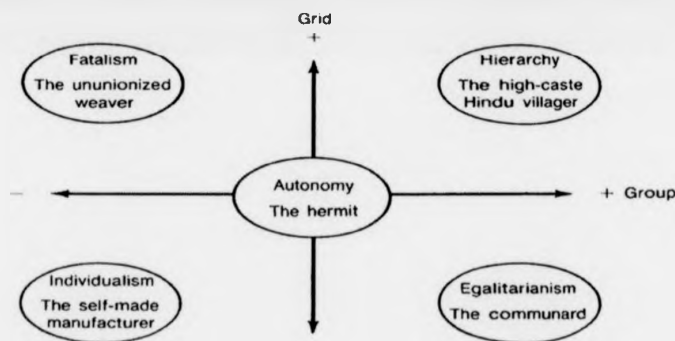
⁹⁴ M. Douglas, *Cultural Bias*, Occasional Paper No 35 (London: Royal Anthropological Institute of Great Britain and Northern Ireland, 1978).

⁹⁵ M. Douglas and A. Wildavsky, *Risk and Culture. An Essay on the Selection of Technological and Environmental Dangers* (Berkeley, Los Angeles and London: University of California Press, 1982).

The more an individual's life was absorbed in the group, for instance working inside the group, marrying inside the group, and so on, the stronger their 'group' score would be.

'Grid' measured rules, 'social classification' or regulation. If social categories of people and their appropriate behaviour were heavily imposed by a culture, then grid was stronger, if behaviour and status were more flexible or left to individual autonomy, then grid was weaker. In combination, these dimensions have produced five possible social forms: hierarchy, egalitarianism, fatalism, individualism and autonomy. These archetypes were extremes, perhaps never found in actual existence, but useful as explanatory tools. To illustrate these archetypes, Thompson, Ellis and Wildavsky have given the examples of the hierarchical high-caste Hindu villager, the egalitarian communitarian, the fatalistic non-unionised weaver, the individualistic self-made manufacturer, and the autonomous hermit (see Figure 1.1).

Figure 1.1: Five Archetypes Mapped onto the Two Dimensions of Social Structure⁹⁶



The 'strong grid' high caste Hindu villager and the non-unionised mill worker were both constrained by a socially imposed 'gridiron' of things they could and could not do, but while the villager was part of a larger hierarchical group which gave him rights to land and deference from those beneath him, the non-unionised mill worker was isolated from other workers and experienced no solidarity with them, lacking also any scope for competition.⁹⁷

⁹⁶ M. Thompson, R. Ellis and A. Wildavsky, *Cultural Theory* (Boulder and Oxford: 1990) p.8.

⁹⁷ *Ibid.* p.9.

The 'weak grid' self-made manufacturer and the self-sufficient communard both considered themselves much freer to act as they pleased, one to hire and fire, and the other to act as equal to his fellow communards, uncontrolled by the perceived coercive world outside the commune. The self-made manufacturer got where he was through rugged individualism, valuing market mechanisms, and using individualistic and pragmatic strategies through networks he had developed himself. The communard was defined through membership of a group that rejected the inequalities of the outside world. The commune's only principle of organization was rejection of those outside the group's boundary; there were no set ways of resolving conflict or reaching decisions inside the commune.

Last of all was the hermit, who was not necessarily reclusive but withdrew from the coercive social involvement of which the other four types became part. He/she valued autonomy above all else, and aimed at a life of relaxed, un beholden self-sufficiency, trying to avoid both the manipulations experienced by the mill worker and the communard, and opportunities for manipulation of others open to the manufacturer and high-cast Hindu. His job might have been driving a taxi, working alone, with ambitions only to be self-sufficient rather than expanding business to work with others.⁹⁸

Corresponding with all these differences, were value systems and strategies relating to all aspects of life, including attitudes to authority, working to long term and short term goals, patterns of consumption and perceptions of nature. Yet people classified in these categories were not conceived of as lifeless automatons, but able to think critically about their situations. The contexts in which they lived were not rigid structures but constantly re-created by individual actions: they were the results of myriad individual decisions made in the past and re-shaped each day.⁹⁹ This brief thumbnail sketch of Cultural Theory cannot do justice to its detail and subtlety, but it is hoped that its value will be perceived more clearly in its application to some of the empirical data in this research project.

Structure of the Thesis

The second chapter continues the literature review in greater depth, exploring developments in drug policies, treatment and services starting from a few years before the period under study. Chapters 3 to 8 set out the results of the original research project, examining key events,

⁹⁸ *Ibid.* pp.5-11.

⁹⁹ M. Douglas, (1978) *op. cit.*, pp.5-6.

developments and structures in the history of the public-private relationship. Chapter 3 reveals the first major policy change in drug treatment since the developments of the late 1960s as the *Treatment and Rehabilitation* report from the Advisory Council on the Misuse of Drugs (1982), and considers how and why it came about. One of its most important consequences was the production of official 'good practice guidelines' (1984) by a medical working group, the first such guidelines in the British health service, and Chapter 4 tells their story. Its new investigation of accusations made by one committee member regarding behind-the-scenes manoeuvres sheds new light on the conduct of medical regulation. Chapter 5 considers the General Medical Council as a major regulatory structure in the public-private relationship, and analyses the cases of Dr Ann Dally, the most high profile private prescriber to be brought before the Council on disciplinary charges between 1983 and 1988. Moving away from professional self-regulation, Chapter 6 focuses on state regulation in the form of the Home Office Drugs Inspectorate and its tribunal system for regulating doctors prescribing controlled drugs. The chapter offers the first in-depth historical study of the Inspectorate. Chapter 7 looks at the third and last major regulatory intervention of the period, the third edition of the good practice guidelines, and the repeated attempts to restrict doctors' prescribing using a system of Home Office licensing. The eighth chapter moves away from formal structures of regulation to consider three less formal professional groupings representing groups of drug doctors and considers the strategies they pursued. None of these groupings have previously been studied. The ninth and final chapter and its conclusions develops a new chronology for the public-private relationship and drug policy, revising that of Chapter 2, and drawing together the thematic findings of the research.

Chapter 2:

Changes in Drug Treatment, Services and Policy, 1965-99

Introduction

To set the public-private debate in context, this chapter has drawn from the published literature to illustrate the changes in drug treatment services and policies of the time. After a period of relative calm in drug policy between the 1930s and the '50s, the last four decades of the century saw a transformation in the way drugs were obtained and used, arousing increasing public and professional interest. Between 1970 and 1999 drug treatment developed amid three key contextual factors: a massive increase in the availability of trafficked drugs in England; a similarly large increase in the numbers of drug users both outside and seeking treatment; and the emergence of HIV/AIDS.

The main sources of information on the availability of drugs and numbers of drug users in treatment were those compiled by the Home Office. Drug availability was gauged through the number of seizures of drugs both at borders and within England by enforcement agencies. As a measure of drugs available in England it was far from accurate. Shortcomings of the data and caveats for interpretation have been described elsewhere.¹ However, as an indicator of relative increases it has proved valuable. Data have also suggested that from 1978 onwards there was a downward trend in the price of trafficked heroin despite there being no reduction in its potency.²

Between 1968 and 1997 it was a statutory requirement for doctors treating patients dependent on opiates or cocaine to notify the Home Office's Addicts Index. Although methods of data collection changed over this period and may not have been comprehensive or entirely accurate for reasons such as the use of false names by drug users or doctors' failure to notify the Index, it was considered the best source for comparisons over more than one decade and gave an indication of the vast increase in the numbers of addicted patients.^{3,4} In 1970, 2657 addicts were notified to the Home Office during the year, while in 1992, after a long rise, 24,703 addicts were notified.⁵

¹ eg Institute for the Study of Drug Dependence, *Drug Misuse in Britain 1996* (London: ISDD, 1997).

² J. Strang, P. Griffiths and M. Gossop, 'Heroin in the United Kingdom: different forms, different origins, and the relationship to different routes of administration', *Drug and Alcohol Review*, 16 (1997), 329-337.

³ J. Mott, 'Notification and the Home Office' in J. Strang and M. Gossop (eds.), *Heroin Addiction and Drug Policy: The British System* (Oxford, New York, Tokyo: Oxford University Press, 1994) pp.270-291.

The impact of HIV/AIDS, once its transmission through injecting drug use became clear, was major. In Britain, HIV was known to have infected drug users in New York by 1984-85 and a few deaths had occurred in Britain, and concern significantly permeated the drugs policy community in 1985.⁶ The reality of its arrival became clear when an epidemic among injecting drug users in Edinburgh was made public in 1986. Complex political manoeuvring preceded the official permission for syringe provision to drug users and the subsequent allocation of specific funding to HIV prevention.

A fragile national consensus emerged which emphasized a pre-existing and more accepting approach to drug use, while attempting to reduce the harm it caused to the user and others, becoming known as 'harm minimization' or 'harm reduction'. Prescribing was used to attract patients into treatment services with the Department of Health promoting a return to the prescription of oral methadone on a maintenance basis to discourage injecting, at a time when such long term prescribing was discouraged. Needle exchanges, which had sprung up through grass routes activism, were introduced officially, albeit on a 'pilot' basis.⁷ The drugs field, long divided between those advocating abstinence as the goal of treatment and those more sympathetic towards maintenance prescribing, saw a shift towards greater consensus after HIV and in 1988 the harm reduction approach received official policy approval.⁸

An analysis of the literature has suggested that drug treatment policies in the period under study could be divided into two chronological phases: 1968-1984 before HIV/AIDS became an issue in drug treatment policies and 1985-1999 afterwards. Gerry Stimson, a sociologist who later became involved with the harm reduction movement, has divided the later period up further, with 1987-97 representing a time when policies were aimed at improving public health, and the health of addicts, and after which treatment policy was directed primarily to reduce drug-related crime.⁹

⁶ J. Strang and C. Taylor, 'Different gender and age characteristics of the UK heroin epidemic of the 1990s compared with the 1980s: new evidence from analyses of national treatment data', *European Addiction Research*, 3 (1997), 43-44.

⁷ J. Mott, (1994) *op. cit.*, p.284.

⁸ V. Berridge, *AIDS in the UK. The Making of Policy, 1981-1994* (Oxford: Oxford University Press, 1996) p.91.

⁹ *Ibid.* pp.119-121; p.221.

¹⁰ H. Hudebine, 'Applying cognitive policy analysis to the drug issue: harm reduction and the reversal of the deviantization of drug users in Britain 1985-2000', *Addiction Research and Theory* (forthcoming).

¹¹ G. V. Stimson, "'Blair declares war': the unhealthy state of British drug policy", *International Journal of Drug Policy*, 11 (2000), 259-264.

1965-1970, The Second Brain Committee

The committee that was responsible for a new age in drug treatment services, the Interdepartmental Committee on Drug Addiction, was chaired by Lord Brain, a former president of the Royal College of Physicians (1950-57). It published its slim report to government, the second Brain Report, in 1965.^{10,11,12,13,14} The committee's membership and the almost wholesale implementation of its recommendations by government reflected the dominance of the medical profession in the formulation of drug treatment policy in the first three-quarters of the twentieth century. In 1961 the same committee's first report had advocated a medical rather than criminal justice approach to drug users, recommending treatment in the psychiatric ward of a general hospital as 'addiction should be regarded as an expression of mental disorder rather than a form of criminal behaviour'.¹⁵ This medical approach was reinforced in the 1965 report with its statement that 'the addict should be regarded as a sick person [and] should be treated as such and not as a criminal, provided that he does not resort to criminal acts'.¹⁶

As a response to the growing number of drug users of a noticeably different social and age demographic, the committee had been reconvened in 1964. Since the 1920s there had been very little opiate addiction and what there was had tended to be concentrated among 'therapeutic addicts' who had acquired their dependence inadvertently through medical treatment and among professionals involved in medicine whose proximity to medicines had facilitated their dependence. They were a diminishing, ageing population who received prescribed drugs and were not generally seen as a cause of social concern. Fears were raised by the press and Parliament, however, in response to the new type of young, usually male drug users, mainly congregating in London from the late 1950s. Between 1960 and 1964, the number of heroin addicts known to the Home Office

¹⁰ H. B. Spear (and ed. J. Mott), *Heroin Addiction Care and Control: The 'British System' 1916-1984* (J. Mott (ed.)), (London: Drugscope, 2002).

¹¹ C. Smart, 'Social policy and drug dependence: an historical case study', *Drug and Alcohol Dependence*, 16 (1985), 169-180.

¹² V. Berridge, *Opium and the People* (first published by (first published 1981 London: Allen Lane; this edition London: Free Association Books, 1999).

¹³ J. Strang, "'The British System': past, present and future', *International Review of Psychiatry*, 1 (1989), 109-120.

¹⁴ G. V. Stimson and R. Lart, 'The relationship between the state and local practice in the development of national policy on drugs between 1920 and 1990' in J. Strang and M. Gossop (1994) *op. cit.*, pp.331-341.

¹⁵ Interdepartmental Committee on Drug Addiction, *Report of the Interdepartmental Committee on Drug Addiction* (London: HMSO, 1961), quoted in Interdepartmental Committee on Drug Addiction, *Drug Addiction. The Second Report of the Interdepartmental Committee* [second Brain Report], Ministry of Health, Scottish Home and Health Department, (London: HMSO, 1965) p.4.

¹⁶ Interdepartmental Committee on Drug Addiction, (1965) *op. cit.*, p.8.

rose from 94 to 342.¹⁷ The number of cocaine addicts also increased from 52 in 1960 to 211 in 1964.¹⁸

The 1965 report, reconsidering its earlier findings, resulted in wide ranging legislative and policy changes. The committee's membership was medical and interpreted its terms of reference 'as meaning that we were not being invited to survey the subject of drug addiction as a whole, but rather to pay particular attention to the part played by medical practitioners in the supply of these drugs'.¹⁹ The second Brain Report concluded that the major source of the new addicts' heroin and cocaine was not trafficked drugs but 'the activity of a very few doctors who have prescribed excessively for addicts'.²⁰ The report perceived there was a need for greater treatment provision and tighter control of supply within a medical framework. Its recommendations were implemented in the 1967 Dangerous Drugs Act and the Dangerous Drugs (Supply to Addicts) Regulations, 1968, which introduced special licences to be granted by the Home Office to doctors wishing to prescribe heroin or cocaine. Between 1968 and 1970 specialist hospital-based drug dependency units (DDUs) were set up, mostly led by consultant psychiatrists and generally in London where the problem was particularly concentrated. In practice, the Home Office almost exclusively limited heroin and cocaine licences to doctors working in the DDUs, which became known as the 'Clinics', and in hospital departments. Until this point many addicts were known by the Home Office through doctors' voluntary reports, inspections of pharmacy registers and inspectors' face-to-face contacts with users. From 1968 formal notification became a statutory requirement and was modelled on infectious disease notification.

The problem of drug use was defined as that of addiction, maintaining the disease model. The second Brain Report described addiction as 'a socially infectious condition'. It has been proposed that prior to the 1960s the medical model was only pursued in terms of individual treatment but that the second Brain Report formulated the disease model to emphasise control within a public health approach.²¹ These developments drew drug users into specialist medical treatment and discouraged general practitioners from involvement, and were not forcefully opposed by GPs.²²

¹⁷ D. Hawks, 'The dimensions of drug dependence in the United Kingdom', in G. Edwards, M. A. H. Russell, D. Hawks *et al* (eds.), *Drugs and Drug Dependence* (Farnborough, Hants., England: Saxon House and Lexington, Mass., USA: Lexington Books, 1976) p.7.

¹⁸ *Ibid.* p.7.

¹⁹ Interdepartmental Committee on Drug Addiction, (1965) *op. cit.*, p.5.

²⁰ *Ibid.* p.6.

²¹ G. V. Stimson and E. Oppenheimer, *Heroin Addiction: Treatment and Control in Britain* (London: Tavistock, 1982) pp.49-53.

²² C. Smart, 'Social policy and drug dependence: an historical case study', *Drug and Alcohol Dependence*, 16 (1985), 169-180.

They also established the DDUs in a dual role of treating drug users and controlling the wider drugs supply to addicts. This control system saw the Clinics as near monopoly suppliers of drugs.²³ In addition to the provision of free prescribed drugs, the mechanisms designed to achieve this were the Addicts Index, which could be checked to see whether a patient was already receiving a supply from another doctor and uphold inter-clinic agreements not to treat each others' patients.²⁴

1970-1984

The Misuse of Drugs Act, 1971 was a substantial piece of legislation, consolidating previous Dangerous Drugs Acts and incorporating heavy criminal penalties. It created an important policy mechanism in the Advisory Council on the Misuse of Drugs (ACMD), (taking over from the earlier Advisory Committee on Drug Dependence established in 1967),²⁵ to advise on future policy responses to the evolving drug scene, and it re-instituted the Home Office's Drug Tribunals, designed to regulate doctors' prescribing of controlled drugs (they had been included in legislation between 1926 to 1961 but had not been used, and are discussed in detail in Chapter 6).²⁶ These came into operation in 1973; in practice the Tribunals were never used against doctors working in the Clinics, only outside. The Act also renamed 'dangerous drugs' as 'controlled drugs'.

In the early years of the DDUs, the numbers of addicts were very small, with only 2240 registered heroin addicts in 1968, and the Clinics seemed able to meet demand.²⁷ Cocaine prescribing was tried out but quickly abandoned.²⁸ Heroin and methadone were prescribed in injectable form on a long term maintenance basis until the end of the mid-1970s. Around this time there was discussion about the relative merits of the three main opiates of prescription: injectable heroin, injectable methadone and oral methadone.²⁹ John Strang, a senior London Clinic psychiatrist and prolific and influential researcher who became one of the key players in the control of prescribing, has reported that by the mid-1970s some Clinics were beginning to introduce a policy that only oral methadone would be prescribed to new patients and by the end of the 1970s most of the Clinics had followed suite. He described a 'therapeutic apartheid' between those patients who had attended the Clinics pre-1975 who often still received maintenance supplies of injectable drugs and those who were

²³ A. Glanz, 'The fall and rise of the general practitioner', in J. Strang and M. Gossop, (1994) *op. cit.*, pp.151-66.

²⁴ T. H. Bewley and R. S. Fleminger, 'Staff/patient problems in drug dependence treatment clinics', *Journal of Psychosomatic Research*, 14 (1970), 303-6.

²⁵ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.170.

²⁶ P. Bean, 'Policing the medical profession: the use of tribunals' in D. K. Whynes and P. T. Bean (eds.), *Policing and Prescribing. The British System of Drug Control* (Basingstoke: Macmillan, 1991) pp.60-70.

²⁷ D. Hawks, (1976) *op. cit.*, p.7.

²⁸ G. V. Stimson and E. Oppenheimer (1982) *op. cit.*, p.99.

²⁹ J. Strang, (1989) *op. cit.*, p.113.

taken on by the Clinics later who were only offered oral methadone.³⁰ These changes, and the mechanisms by which they were achieved, are considered in detail in Chapters 3, 4 and 8.

Major changes also took place in England's illicit drug supply: until 1979 prescribing remained the main source of opiates and other drugs both legitimately and on the illicit market, with patients selling or sharing the excess from their prescriptions. H. B. 'Bing' Spear, Chief Inspector at the Home Office between 1977 and 1986, recalled that some expensive smuggled Chinese heroin could be found but relatively small quantities of trafficked drugs were entering the country.³¹ However, from 1978-79 the quantity of trafficked heroin in England increased,³² as did the numbers of heroin users both outside and seeking treatment. Instead of being the chief guardians of the drug supply, doctors found themselves faced with major competition from a fully fledged black market in imported heroin.

Although the Clinics had been set up with an aim of undercutting the black market through 'competitive prescribing', they had abandoned this model by the late 1970s. The near monopoly of treatment they held, had allowed the Clinics to become unresponsive to the preferences of their patients, while the private doctors were able to supply the unmet demand.³³

Until the 1980s most of England's heroin use and its treatment provision had been concentrated in London, but where heroin spread across the country, drug services were slow to follow.³⁴ What Clinics there were had insufficient treatment places and found that drug users were increasingly looking elsewhere for treatment. The Home Office Addicts Index³⁵ showed that over the 1970s the proportion of patients seeing both private and NHS GPs grew in both absolute terms and as a proportion of all those seen by doctors. After the establishment of the Clinics, NHS doctors in general practice had had little involvement in the treatment of addiction and minimal training. In 1970 GPs only notified 15 per cent (111) of all addicted patients to the Addicts Index in 1970. This rose to 29 per cent (264) of notifications in 1975 and 53 per cent (1191) in 1981.³⁶

³⁰ *Ibid.* p.113.

³¹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.228.

³² R. Lewis, R. Hartnoll, S. Bryer *et al.*, 'Scoring smack: the illicit heroin market in London 1980-1983', *British Journal of Addiction*, 80 (1985), 281-290.

³³ A. Glanz, (1994) *op. cit.*, p.155.

³⁴ D. Turner, 'The development of the voluntary sector: no further need for pioneers?' in J. Strang and M. Gossop (1994) *op. cit.*, pp.222-230.

³⁵ Under the law, doctors were obliged to notify to the Home Office Addicts Index anyone they attended who was dependent on certain specified opiates or cocaine. Doctors were encouraged to phone the Addicts Index to find out if anyone for whom they were about to prescribe a drug was already receiving a prescription from another doctor.

³⁶ ACMD, *Treatment and Rehabilitation*, DHSS (London: HMSO, 1982) p.120.

Outside the NHS

While government and the medical profession chiefly shaped services within the NHS, the voluntary and private sectors tended to play the role of meeting unmet demand either for profit or otherwise. 'Voluntary sector' has been used here to encompass charities and other non-statutory, non-profit organisations. Voluntary organisations set up to help drug users with social and health problems were numerous in the drugs field. The late 1960s saw a growth in street services and day centres providing social care and counselling in London and other cities, some church based, usually following a social rather than medical model, but often with close links to treatment services.

The UK's first Narcotics Anonymous (NA) began in 1979, modelled on Alcoholics Anonymous, a '12-step' or 'Minnesota Model' fellowship. These meetings aimed at maintaining daily abstinence from all mood altering drugs, with attendance and 'recovery' going long beyond initial detoxification. Psychiatrist Brian Wells, a 12-stepper himself, described a common cynicism both among users and professionals regarding NA in the early 1980s, but despite this the movement continued to grow.³⁷ Voluntary services were represented by the umbrella organisation, the Standing Conference on Drug Abuse (SCODA), set up in 1973.

Those working within the NHS were also involved in voluntary sector projects and their approaches had mutual influence. Griffith Edwards, an NHS psychiatrist who had started and run the Institute of Psychiatry's Addiction Research Unit, was instrumental in establishing Phoenix House, an abstinence based therapeutic community modelled on its original in New York. John Strang has suggested that these and other similar abstinence rehabilitation houses in the UK influenced the move against maintenance prescribing in the late 1970s and early '80s.³⁸

A system under strain

Despite the expansion of specialist care from London to the provinces – by 1975 there were 15 outpatient DDUs in London and 21 in the rest of the country – the continuing increase in the number of drug users put pressure on their ability to meet demand.³⁹ Disillusionment was not limited to the Clinics: the oil crisis of 1973 had had an immense impact on the British economy and the following years had brought optimistic expectations about future investment in the health service to an end. Webster explained, 'Until that time, it was confidently anticipated that the

³⁷ B. Wells, 'Narcotics Anonymous (NA) in Britain', in J. Strang and M. Gossop (1994) *op. cit.*, pp.240-247.

³⁸ J. Strang, (1989) *op. cit.*, p.113.

³⁹ DHSS, *Better Services for the Mentally Ill* (London: HMSO, 1975) pp.68-69.

economic system was capable of achieving a rate of growth sufficient to meet rising social expectations.⁴⁰

Optimism did not return swiftly as from 1974 to 1979 four factors created a state of crisis and demoralization in the health service: cuts in public expenditure; Sir Keith Joseph's reorganisation; resentment from vulnerable groups about the failure to improve services; and the failure in leadership of health ministers.⁴¹ The hospital service in particular lost its previous protection from spending cuts from 1974 and this coincided with pressure from the introduction of stricter financial disciplines into health spending plans.⁴²

The second Brain Report had anticipated that controls on the prescription of heroin and cocaine would be sufficient to deal with demand, but once the prescription of those drugs was under tighter control, there seems to have been a move among patients to obtain other drugs from doctors outside Clinics. The Iranian Revolution, with its resultant emigration, helped establish a new heroin route into Britain from the Gulf, meeting demand of existing addicts no longer supplied by the DDUs, and spreading use across the country on a previously unimagined scale. This source was then superseded by Turkish heroin in 1980 and then the following year's major supplier became Pakistan.⁴³

Yet it is perhaps unsurprising that a medical committee which had restricted its remit to the role of medical practitioners in the supply of drugs, rather than 'drug addiction as a whole',⁴⁴ did not consider or anticipate the subsequent changes in the international drugs trade. As the DDUs had been set up with the aim not only of treating but of controlling the spread of addiction, the penetration of trafficked heroin into new areas of the country in the 1970s and most dramatically from 1979, provided a basis for the criticism that the Clinics had failed. In some circles, this was presented as a failure of the 'medical model'.⁴⁵ Others responded by criticising maintenance prescribing about which they had long felt uncomfortable.⁴⁶

⁴⁰ C. Webster, *The National Health Service. A Political History* (Oxford: Oxford University Press, 1998) p.138.

⁴¹ *Ibid.* pp.138-139.

⁴² *Ibid.* p.111.

⁴³ Anonymous, 'What's happening with heroin?' *Druglink Information Letter*, ISDD, 17 (1982), 1-5.

⁴⁴ Interdepartmental Committee on Drug Addiction, (1965) *op. cit.*, p.5.

⁴⁵ M. Ashton, 'Controlling addiction: the role of the Clinics', *Druglink Information Letter*, ISDD, 13 (1980), 1-6.

⁴⁶ eg P. H. Connell, '1985 Dent Lecture: "I need heroin". Thirty years' experience of drug dependence and of the medical challenges at local, national, international and political level. What next?', *British Journal of Addiction*, 81 (1986), 461-472.

The Reluctant Re-entry of General Practice

In 1968 GPs had lost the authority to prescribe heroin and cocaine to their addict patients, although they could still prescribe them for the treatment of pain and some other indications. Other opiates like methadone could be prescribed by all doctors for the treatment of drug dependence. Until the 1980s, most general practices in England and Wales had had little to do with the management of drug misuse. The opposite was the case in Scotland, where there was little specialist involvement.⁴⁷ Due to the relatively small numbers of drug users in the 1970s, few GPs were affected by the problem. By the early 1980s the situation had changed and the policy community responded. However, as drug use, and particularly heroin addiction, increased significantly from 1979, drug users sought help from their GPs, bringing them into the picture in an unplanned way.⁴⁸ The ACMD addressed this state of affairs in 1982 and recommended that renewed GP involvement become official policy alongside the Clinics.⁴⁹ The government responded to these recommendations and an ongoing battle began between forces encouraging GP involvement, (emanating from both specialists and generalists, the drug policy community and central government) and the many reluctant GPs, supported in the 1990s by their trade union, the General Medical Services Committee of the British Medical Association. Their reluctance was largely based in the unpopularity of drug addicts as patients, and uncertainty over whether drug problems constituted an appropriate sphere for medical intervention, even among those who treated them as patients.⁵⁰ Similar attitudes have been noted in doctors' attitudes towards alcoholic patients, described in sociologist Philip Strong's study of doctors and 'dirty work'.⁵¹

Polydrug use and the Clinics

In the 1970s, a pattern of use distinctive to Britain emerged, with drug users injecting barbiturates often in combination with other drugs. The hypnotic and tranquilliser drugs used became seen as a major problem for accident and emergency departments, particularly in London, due to frequent overdosing,⁵² and aggression towards casualty staff.⁵³ Through the 1970s barbiturates were the drugs most commonly involved in overdose deaths among addicts. After experimentation, it was concluded that barbiturates were not a suitable drug for maintenance therapy through the Clinics,

⁴⁷ V. Berridge, (1996) *op. cit.*, p.92.

⁴⁸ A. Glanz, (1994) *op. cit.*, pp.155-156.

⁴⁹ ACMD, (1982) *op. cit.*, pp.81-86.

⁵⁰ N. McKeganey, 'Shadowland: general practitioners and the treatment of opiate-abusing patients', *British Journal of Addiction* 83 (1988), 373-386.

⁵¹ P. M. Strong, 'Doctors and dirty work - the case of alcoholism', *Sociology of Health and Illness*, 2 (1980), 24-47.

⁵² H. Ghodse, A. Oyefeso and B. Kilpatrick, 'Mortality of drug addicts in the UK, 1967-1993', *International Journal of Epidemiology*, 27 (1998), 473-478.

⁵³ A. H. Ghodse, 'Drug problems dealt with by 62 London casualty departments', *British Journal of Preventive and Social Medicine*, 30, 4 (1976), 251-256.

who were later criticised for their apparent inability to respond to polydrug use, and barbiturates in particular.⁵⁴ Whether, in fact, polydrug use was a new phenomenon in the 1970s or had always been part of the non-therapeutic drug use addressed by the second Brain Committee, was unclear. Gerry Stimson and Edna Oppenheimer noted that in 1964 virtually all the cocaine users known to the Home Office were also addicted to heroin.⁵⁵

In 1975 the ACMD launched the 'Campaign on the Use and Restriction of Barbiturates' (CURB), to reduce barbiturate prescribing by doctors. According to Bing Spear, Chief Inspector at the Home Office Drugs Branch at the time, 'As an effective response to the barbiturate-injecting problem, CURB was a singularly futile exercise, which merely postponed the day when realistic controls would have to be imposed.'⁵⁶ Barbiturates eventually became controlled drugs in 1984, but by this time the problem had already diminished, possibly because of the increasing availability of trafficked heroin in the 1980s.⁵⁷

As barbiturates fell from favour, benzodiazepines were mistakenly prescribed as the non-addictive substitute for barbiturates,⁵⁸ and use by addicts followed suit. By 1986-87, benzodiazepines were commonly available from GPs and on the streets.⁵⁹ In Scotland in particular, a 'non-injectable' gel-filled oral temazepam capsule was formulated to prevent this use, but persistent injectors suffered horrific injuries and disease during the 1980s and '90s. In 1992 the ACMD called for restrictions on the prescription of temazepam, but legislative change did not follow until three years later. An alternative, and, in the eyes of the BMA, very effective approach to restricting the black market in temazepam gel-filled capsules was pursued by banning the formulation from National Health Service prescription.⁶⁰

The Central Funding Initiative (1983-89)

Responding favourably to the recommendations of the Advisory Council on the Misuse of Drugs,⁶¹ the Department of Health and Social Security prepared a large new source of funding to cover start-up costs for new services. This 'Central Funding Initiative' (CFI) consisted of £17.5

⁵⁴ A. Gilanz, (1994) *op. cit.*, p.155.

⁵⁵ G. V. Stimson and E. Oppenheimer, (1982) *op. cit.*, p.49.

⁵⁶ H. B. Spear, (2002) *op. cit.*, p.258.

⁵⁷ Working Party of the Royal College of Psychiatrists and the Royal College of Physicians, *Drugs, Dilemmas and Choices* (London: Gaskell, 2000) p.50.

⁵⁸ *Ibid.* p.50.

⁵⁹ R. Power, 'Drug trends since 1968', in J. Strang and M. Gossop (1994) *op. cit.*, pp.29-41, p.33.

⁶⁰ British Medical Association, *The Misuse of Drugs* (Amsterdam: Harwood Academic Publishers, 1997) p.22.

⁶¹ ACMD, (1982) *op. cit.*, pp.81-86.

million distributed in 188 grants over 6 years and had a number of goals.⁶² It aimed at funding local initiatives, such as the development of cross-agency problem drug teams, the development of community-based responses across the country, and integration of drug services into mainstream health services. On the quiet it was also intended to shift the concentration of services and power away from the London psychiatric Clinic consultants.⁶³

This initiative and the return of GPs have also been linked to a 'normalization' of drug services in the early and mid-1980s, as drug use and drug dependence became more common and drug services were integrated into mainstream healthcare.^{64,65} From this encouragement of the voluntary sector followed a new status and recognition given by policy documents to its role in mid-1980s.⁶⁶ Although acknowledging the importance of the Central Funding Initiative, David Turner, who represented voluntary drug services from 1975 to 1994 as Co-ordinator of SCODA, considered that the sector's strong influence and growth pre-dated the flow of money from the CFI by a couple of years.⁶⁷ However, it may be that Turner preferred to see voluntary services as responding sensitively to local demand rather than following central edict.

1985-1999

British drug policy during the 1980s has received academic interest from sociologists, anthropologists and historians.^{68,69,70,71} Agreement has emerged over a number of the themes of this period: that community drug services, both voluntary and statutory, expanded during the 1980s; that the professional groups involved in drug treatment and policy increased and diversified; that GPs re-entered the picture, albeit reluctantly, after over a decade's absence; and that in response to HIV/AIDS, drug and treatment policies liberalised in the late 1980s, with 'harm reduction' becoming official policy in 1988.

⁶² S. MacGregor, B. Eitorre, R. Coomber, *et al.*, *Drug Services in England and the Impact of the Central Funding Initiative*, ISDD Research Monograph One (London: ISDD, 1991).

⁶³ V. Berridge, (1996) *op. cit.*, p.94.

⁶⁴ A. Glanz, (1994) *op. cit.*, pp.155-158.

⁶⁵ J. Strang, 'A model service: turning the generalist on to drugs' in S. MacGregor (ed.), *Drugs and British Society. Responses to a Social Problem in the 1980s* (London and New York: Routledge, 1989) pp.143-169.

⁶⁶ G. V. Stimson, 'British drug policies in the 1980s: a preliminary analysis and suggestions for research', *British Journal of Addiction* 82, 5 (1987), 477-488.

⁶⁷ D. Turner, (1994) *op. cit.*, p.222.

⁶⁸ eg N. Dorn and N. South (eds.), *A Land Fit for Heroin? Drug Policies, Prevention and Practice* (Basingstoke: Macmillan, 1987).

⁶⁹ S. MacGregor (ed.), *Drugs and British Society. Responses to a Social Problem in the 1980s* (London and New York: Routledge, 1989).

⁷⁰ eg V. Berridge, 'Historical issues' in S. MacGregor (1989) *op. cit.*, pp. 20-35.

⁷¹ K. Duke, *Drugs, Prisons and Policy Making* (London: Macmillan, 2003).

Later observations by Stimson defined 1997 as the beginning of yet another new phase, with the election of the Blair government. This, he claimed, brought an end to the 'public health approach', dated from 1987, where 'the aim was to help problem drug users to lead healthier lives, and to limit the damage they might cause themselves or others' and introduced an 'unhealthy' 'punitive and coercive ethos' for dealing with dependent drug users.⁷²

Behind these policies, drug use continued to rise, spread to new parts of the country, and diversify. New drugs and new formulations joined the existing array of substances, while others dropped from availability or favour. Heroin use climbed through the eighties and nineties, joined by 'crack', a new smokeable form of cocaine, which came from the United States in the mid-1980s and grew to considerable popularity. Ecstasy, (the street name for 3,4-methylene-dioxymethamphetamine) a stimulant with empathy-inducing properties, became popular as a 'dance drug' at parties and clubs, usually taken as an oral tablet, along with other stimulants and psychedelic drugs. Amid great public and media concern over a small number of sudden deaths associated with the drug, educational responses were launched, but no individual treatment was provided. Meanwhile cannabis remained the most popular drug in England throughout this period, with demands for reduced penalties or legalisation becoming increasingly common and less controversial.

GPs and Community Based Services

From the beginning of their re-involvement, with the exception of a small number of enthusiasts, and despite concerns over HIV/AIDS in the latter 1980s and 1990s, GPs remained reluctant to prescribe substitute drugs to addicts. In 1990 GP Tom Waller, prominent for his encouragement of his peers, proposed additional payments to GPs as an incentive for treating drug users.⁷³ Although criticised as expensive, possibly unethical, and probably ineffective,⁷⁴ the idea was taken up by GP negotiators in 1996 who declared that treatment of drug misuse was no longer to be considered part of their contract to provide general medical services but required an additional fee.⁷⁵ While there were a few local arrangements paying extra, the Department of Health did not move on the issue.

Despite GPs' wariness of addicts, commentators noted a shift from specialist to generalist services during the 1980s. The 1984 clinical guidelines and subsequent DHSS circulars reinforced this,

⁷² G. V. Stimson, (2000) *op. cit.*, p.259-264.

⁷³ See A. Glanz, (1994) *op. cit.*, p.162.

⁷⁴ *Ibid.* p.162.

⁷⁵ British Medical Association. General Medical Services Committee, *Core Services: Taking The Initiative* (London: British Medical Association, 1996).

making drug services more like other areas of the NHS, where it was unusual for any condition to be solely addressed by specialists. Criminologist Alan Glanz has linked the revival of GPs' involvement in drugs, and the emphasis on 'community' rather than specialist or institutional care, to their rising status as a group. GP leaders had been working to establish general practice as a 'specialty' with academic departments and compulsory vocational training. Improved terms and conditions had followed and by 1984 it had changed from being an unpopular career choice for medical students to the most desirable.⁷⁶

Sociologists Gerry Stimson and Rachel Lart have argued that British drug policy could not be considered as a separate arena but reflected wider changes in social policy and health services, being determined in the 1960s and '70s by the relationship between the state and the medical profession, and from the 1980s with the addition of social services as a third player.⁷⁷

Political encouragement of private medicine, which strengthened through the 1980s and 1990s, related mainly to those funded by insurance premium, rather than direct payment by the patient, and did not concern private prescribers. Early after achieving power, the Conservatives abolished the Health Services Board, established by Labour to supervise the private hospital sector and phase out private beds from the NHS,⁷⁸ but private prescribing was almost overwhelmingly on an out-patient basis. The little written by academic researchers on private drug doctors noted that they continued to have a role, which remained controversial, and in the 1980s attempted to improve their status through the Association of Independent Doctors in Addiction (AIDA).⁷⁹

AIDS and Official Harm Reduction

Once those in the drugs field had started to see HIV/AIDS as an important threat, a number of policy options were available in response. Hard line campaigns against drug use had emerged from the Conservative government in 1985-86, and at the same time a penal approach both at a political rhetorical and policy level pressed through legislation to freeze, trace and confiscate money from drug dealing, and to increase penalties for trafficking.⁸⁰ Berridge's research has shown that, while a continuation of this penal and stigmatising approach might have been expected from the New Right, in the event, it was a non-coercive public health approach that won out. The struggle behind this owed much to medical bureaucrats in the Department of Health, in alliance with outside

⁷⁶ A. Glanz, (1994) *op. cit.*, p.159.

⁷⁷ G. V. Stimson and R. Lart, (1994) *op. cit.*, pp.339-340.

⁷⁸ R. Klein, *The New Politics of the NHS*, (first published 1983, London and New York: Longman; fourth edition, Harlow: Prentice Hall, 2001).

⁷⁹ G. V. Stimson, (1987) *op. cit.*, p.339.

⁸⁰ V. Berridge, (1996) *op. cit.*, pp.93-94.



pressure groups in the voluntary sector. As a result, AIDS brought together politicians and 'experts' in an alliance based on minimising the harm from drug use, rather than eradicating or curing it, using needle exchange as the means to achieve this.⁸¹

Although given the new name of 'harm reduction', this approach had a long history, with antecedents in the 1880s and 1960s.⁸² Rather than the drugs policy community switching wholesale from one approach to another, controversy over different methods of dealing with drug use had existed since at least the 1960s, with different groups gaining ascendancy at particular moments. 'Fixing rooms' for instance, where injectors could take their prescribed drugs, had existed in the early 1970s, but along with the provision of injecting equipment, had been phased out by 1975 as the Clinics moved to providing oral drugs.⁸³ The voluntary sector had always pursued a more 'harm reductionist' approach but advocated it more openly after 1986.⁸⁴

The significant policy event of that year was the McClelland Report from a committee set up by John Mackay at the Scottish Home and Health Department under the chairmanship of Dr D. B. L. McClelland. From a committee membership not derived from the drugs field, it was this document which first officially championed a harm reduction approach in relation to AIDS including the establishment of needle exchanges. This position has often erroneously been given to the ACMD, whose report *AIDS and Drug Misuse* did not come out until 1988.^{85,86} Scotland had taken the lead on this approach as the problem of HIV among injecting drug users had been effectively publicized by Dr Roy Robertson, a GP practicing in the deprived Muirhouse area of Edinburgh. In 1985, he had found levels of HIV among his injecting patients of around 50%.⁸⁷

Harm reduction, which became official British policy in 1988, changed prescribing once again. AIDS made long-term prescribing a legitimate option, and appeared to resolve 'the prescribing question that had bedevilled drug policy in the 1970s and 1980s'.⁸⁸ The 1960s and 70s policy of 'competitive prescribing' was revived to attract drug users into treatment, albeit with oral methadone, rather than injectable heroin.

⁸¹ *Ibid.* pp. 220-225.

⁸² V. Berridge, 'AIDS and British drug policy: continuity or change?' in V. Berridge and P. Strong (eds.), *AIDS and Contemporary History* (Cambridge: Cambridge University Press, 1993) pp. 135-156.

⁸³ D. Turner, (1994) *op. cit.*, pp. 225-226.

⁸⁴ V. Berridge, (1993) *op. cit.*, pp. 146-148.

⁸⁵ ACMD, *AIDS and Drug Misuse* (London: DHSS, 1988).

⁸⁶ eg A. Preston and G. Bennett, 'The history of methadone and methadone prescribing', in G. Tober and J. Strang (eds.), *Methadone Matters: Evolving Community Methadone Treatment of Opiate Addiction* (London: Martin Dunitz, 2003) pp. 13-20, p. 19.

⁸⁷ V. Berridge, (1996) *op. cit.*, p. 92.

⁸⁸ V. Berridge, (1993) *op. cit.*, p. 146.

Just as proponents of 'harm reduction' did not appear overnight in 1988, neither were its earlier opponents complete converts under the new 'consensus'. Furthermore, 'harm reduction' meant different things to different professional groups.⁸⁹ Political scientist Hervé Hudebine noted that the 1991 edition of the clinical guidelines,⁹⁰ chaired by the most senior addiction psychiatrist, John Strang, emphasised the importance of harm reduction, but reasserted abstinence as a primary goal, and advised GPs against undertaking methadone maintenance without specialist advice. Through this the specialists, who had had to face competition from other sectors both in financial and policy terms since the first half of the 1980s, reaffirmed their primacy.⁹¹

Part of the government's strategy against HIV/AIDS involved funding research not just on epidemiology and biology but also on the intimate behaviour of drug users, including their injecting and sexual practices.⁹² Government research grants went from a total of £2.5 million in 1986/87 to around £23 million in 1992/93.⁹³ Stimson hinted at a decline in this funding during the late 1990s in his attack on the Blair Government, and its implications for the relationship with government of experts dependent on such funding, but no serious study of the effects have been made.⁹⁴

Hudebine put some of these changes a little earlier, noting that 'harm reduction', although still pursued at local level, had almost disappeared from the national policy agenda in 1995-96 and that ear-marked funds for health authorities to prevent AIDS also ceased after 1993.⁹⁵ Sociologist Nigel South has observed, however, that harm reduction continued as a policy priority in Scotland.⁹⁶

Drugs and Crime

While possession and distribution of drugs controlled under the Misuse of Drugs Act, 1971, were usually crimes in themselves,⁹⁷ public and policy concern over drug-related crime during this period tended to mean acquisitive crime perpetrated to obtain the means to buy addictive drugs, and sometimes violent crime resulting from intoxication.

⁸⁹ H. Hudebine, (forthcoming) *op. cit.*

⁹⁰ Department of Health, Scottish Office Home and Health Department, and Welsh Office, *Drug Misuse and Dependence. Guidelines on Clinical Management* (London: HMSO, 1991).

⁹¹ H. Hudebine, (forthcoming) *op. cit.*

⁹² J. Strang, G. V. Stimson and D. C. Des Jarlais, 'What is AIDS doing to the drug research agenda?', *British Journal of Addiction*, 87 (1992), 343-346.

⁹³ V. Berridge, (1996) *op. cit.*, p.276.

⁹⁴ G. V. Stimson, (2000) *op. cit.*, p.264.

⁹⁵ H. Hudebine, (forthcoming) *op. cit.*

⁹⁶ N. South, 'Tackling drug control in Britain: from Sir Malcolm Delevingne to the new drugs strategy' in R. Coomber (ed.), *The Control of Drugs and Drug Users. Reason or Reaction?* (Amsterdam: Harwood Academic Publishers, 1998) pp.87-106.

⁹⁷ An exception might be, for instance, possession of a Schedule 2, such as heroin, with a prescription.

Estimates varied as to what proportion of crime was committed by drug users in pursuit of their substance. In the mid-1990s politicians and drugs policy researchers produced contradictory estimates, with researchers emphasizing the range of income sources available to dependent heroin users other than acquisitive crime.^{98,99} In the late 1990s, however, there seemed to be emerging consensus in the drug policy field, as well as among politicians, of the importance of links between dependent drug use and acquisitive crime. A literature review showed that dependent heroin users, disproportionately likely to be poor people in deprived communities, were very likely to resort to burglary, shoplifting, fraud and theft to pay for drugs.¹⁰⁰ Stimson observed with dismay the changes he observed in treatment services that flowed from making this connection. Focusing treatment on reducing drug use in order to curb drug-related crime broke the post-AIDS public health consensus, which had prioritised the prevention of blood borne disease and pursued harm reduction as a humanitarian goal.¹⁰¹

While some of Stimson's concerns related to anticipation of the future direction of such policies, some initiatives were already in place by the end of the century. Drug treatment and testing orders (DTTOs), influenced by American 'drug courts', could 'sentence' a drug user to treatment rather than prison, with freedom dependent on monitored results, and were piloted by the Criminal Justice Act, 1998. Without waiting for the pilot study's conclusions, the Home Secretary extended DTTOs across the country. Until this point, there had been little coercive treatment in England,¹⁰² although it had been discussed since the 1880s and was recommended by the second Brain Committee.

Another linking mechanism used in the 1990s was arrest referral schemes, where drugs workers sought out drug users in the criminal justice system, often in police cells, and referred them to treatment. Here though, involvement with the schemes was voluntary and not an alternative to prosecution. Although these multiplied from 1999 onwards, they had been in existence before this, and some have seen arrest referral as part of a liberal rather than penal approach.¹⁰³

⁹⁸ eg. Labour Party, *Drugs: The Need for Action* (London: Labour Party, 1994).

⁹⁹ eg. N. Dorn, O. Baker & T. Seddon, *Paying For Heroin: Estimating The Financial Cost Of Acquisitive Crime Committed by Dependent Heroin Users in England and Wales* (London: ISDD, 1994).

¹⁰⁰ H. Parker, C. Bury, and R. Egginton, *New Heroin Outbreaks Amongst Young People in England and Wales*, Crime Detection and Prevention Series, Paper 92 (London: Home Office Police Policy Directorate, 1998) pp.6-7.

¹⁰¹ C. V. Stimson, (2000) *op. cit.*, p.259-264.

¹⁰² P. J. Turnbull, T. McSweeney, R. Webster, *et al.*, *Drug Treatment and Testing Orders: Final Evaluation Report*, Home Office Research Study 212 (London: Home Office Research, Development and Statistics Directorate, 2000) pp.1-7.

¹⁰³ H. Hudebine, (forthcoming) *op. cit.*

So has Stimson over-emphasised the starkness of policy change from public health to crime prevention in the pre and post Blair era to make a political point?¹⁰⁴ Berridge took the view that penal policy persisted during the era of harm reduction, albeit in a modified form, and that coercive approaches to drug and alcohol treatment had their roots as far back as late nineteenth century inebriates legislation. Between 1987 and 1997 Britain did not depart from the international or European systems of drug control and at a local level, police were involved in drug advisory committees, co-operating in the establishment of needle exchanges.¹⁰⁵ Furthermore, the option of diverting drug users into treatment rather than prison had become government policy as long ago as 1990 in the Government's White Paper *Crime Justice and Protecting the Public*. Berridge, writing in the early 1990s, considered the balance of power between penal and medical approaches post-AIDS to be too complex to be 'adequately subsumed under rhetorical barriers such as the "public health" approach of drug policy.'¹⁰⁶ Furthermore, Stimson has overlooked the potentially coercive role of public health, which has used powers of compulsory quarantine and notification.

Voluntary Services

As mentioned, voluntary services were critical to the direction of policy and service provision post-HIV, although initially divided on the issue of needle exchanges.¹⁰⁷ The distinction between 'voluntary' and 'statutory' had become somewhat blurred over the period of study by government funding of voluntary sector organisations. This trend strengthened in the 1980s when the Conservative Government started to contract out many statutory services to the voluntary sector.

SCODA's David Turner claimed that the establishment of voluntary services had not diminished their role as advocates of drug users and agitators for change. And, although government funding could be seen as a way of controlling these organisations, and reining in their radicalism, Berridge, in her work on the anti-tobacco pressure group Action on Smoking and Health, has shown how state support for a radical group outside government could serve to lobby for change desired by but unvoiceable from government.¹⁰⁸ Turner himself, writing after needle exchange had become orthodoxy, explained voluntary drug services' fears over endorsing harm reduction as a result of

¹⁰⁴ In 2000 Gerry Stimson helped to establish and became Chair of the UK Harm Reduction Alliance to campaign for harm reduction policies.

¹⁰⁵ V. Berridge, (1993) *op. cit.*, pp.138-152.

¹⁰⁶ *Ibid.* p.152.

¹⁰⁷ V. Berridge, (1996) *op. cit.*, pp.91-92.

¹⁰⁸ V. Berridge, 'Issue network versus producer network? ASH, the Tobacco Products Research Trust and UK smoking policy' in V. Berridge (ed.), *Making Health Policy: Networks in Research and Policy After 1945* (Amsterdam: Rodopi, 2005) pp.101-124.

threats to funding when they were perceived 'as having gone too far',¹⁰⁹ suggesting that control was still an element in state funding.

Professionalization was a feature of the 1980s and continuing in the 1990s in the voluntary sector, including greater requirement for formal qualifications among staff, management standards, performance measures and other bureaucratic features demanded by those contracting their services. Also emerging in the 1990s was drug user activism, agitating for changes to services and legislation.¹¹⁰

As well as providing statutory services, the voluntary sector also saw the growth of self help groups in the 1980s and 1990s. Narcotics Anonymous continued to spread fairly evenly across the country with 223 weekly meetings by 1991. There were also residential 12-step treatment centres in the private and voluntary sectors, with 'a diluted version' sometimes found in NHS addiction units. By 1991 there were 30 treatment centres in the UK and Ireland providing Minnesota Model drug-free style treatment.¹¹¹

Local Arrangements

In treatment services, local arrangements were encouraged by central government during the 1990s. Chief among these exhortations came 'shared care', which involved a formal division of a patient's workload between specialist psychiatrists and GPs.¹¹²

Local inter-agency co-operation had been encouraged for many years, but from 1995, there was a radical departure to the established arrangements with the setting up of Drug Action Teams in every health district. Their memberships comprised a small number of budget holders ideally representing key local authorities, services and criminal justice agencies. Their aim was to reduce drug-related harm in accordance with the targets set by the Conservative Government's White Paper *Tackling Drugs Together*. These goals were both aimed at reducing drug supplies and demand for drugs and encompassed both penal and harm reduction approaches. Each Drug Action Team was advised by a Drug Reference Group made up of local people with expertise in the various services and these arrangements persisted through to the end of the century with minor modification. Similar but separate arrangements were set up following strategies for Wales,

¹⁰⁹ D. Turner, (1994) *op. cit.*, p.228.

¹¹⁰ *Ibid.* p.229.

¹¹¹ B. Wells, (1994) *op. cit.*, pp.241-246.

¹¹² eg UK Health Departments, *Drug Misuse and Dependence: Guidelines on Clinical Management* (London: The Stationery Office, 1999) pp.10-15.

Scotland and Northern Ireland. Later, under Labour, Drug Action Teams became responsible for commissioning and evaluating drug services.

Wider Changes in Health Services, Public and Private

If drug treatment services had joined the mainstream in the 1980s, what was happening in the rest of the health service? A major theme of the 1980s and '90s in the rest of the health service was the changing relationship between the centre and the periphery, with management becoming increasingly important. Before the 1974 reorganisation of the NHS, 'management was conspicuous by its absence'. Administrators and treasurers did not take a proactive line in developing services, which was left to the medical profession.¹¹³ This was followed by a period of 'consensus management' that tended to reinforce the strong position of the medical profession but all this changed with the election of the Conservative government in 1979. From then on, the NHS underwent 'continuous revolution'.¹¹⁴ The medical profession's assumed right to consultation over NHS changes was not honoured by Margaret Thatcher, and even employment terms and conditions could be imposed without mutual agreement.¹¹⁵

General management was introduced in 1984-85, providing for the first time, according to Stimson and Lart, an effective central mechanism for controlling peripheral activity beyond budgetary control. However, this central control paradoxically encouraged devolved decision-making, which in turn led to a huge increase in guidelines, directives and circulars from the centre advising the periphery on how it was to carry out these devolved responsibilities.¹¹⁶ The Central Funding Initiative could be seen as part of this pattern, encouraging the development of locally autonomous services, while orchestrating them from the centre. Throughout the 1990s, management of the NHS was lead by the NHS Executive, with centralisation becoming stronger in the second half of the decade.

Most controversial was the introduction of market reforms and a split between 'purchasers' of health care, general practitioners and health authorities, and providers, hospitals and community services, following 1989's White Paper *Working for Patients*. With providers' budgets dependent on the success of their services in attracting patients, the idea was that consumer choice and efficiency would both improve. From this major change arose a pressure to quantify the outcomes of treatment for comparison and to standardize treatment through the use of clinical guidelines,

¹¹³ G. V. Stimson and R. Lart, (1994) *op. cit.*, pp.334-335.

¹¹⁴ C. Webster, (1998) *op. cit.*, pp.140-214.

¹¹⁵ R. Klein, (2001) *op. cit.*, pp.169-172.

¹¹⁶ G. V. Stimson and R. Lart, (1994) *op. cit.*, pp.336-339.

coinciding with the emerging 'evidence-based medicine' movement in the medical profession, which favoured guidelines as a distilled, applied source of research findings. The market endured under John Major's premiership, but was partially dismantled by Tony Blair, reflecting its unpopularity with the public.

One of the themes of John Major's period of office noted by Klein was the transformation of NHS patients into 'consumers'. The *Patient's Charter* (1991) outlined patients' consumer rights for the first time, although more symbolic and rhetorical in significance than in actually producing change. The extent to which NHS patients were able to exercise effective choice as consumers has been questioned.¹¹⁷ Consumerism was also a popular theme with New Labour, appealing as it did across employees and employers, the constituents of 'old' Labour and the New Right.

With the rejection of competition as the spur of change in the NHS, the managerialism of the early and mid-1980s was revived in the late 1990s. Producing clinical guidelines and other advice was a new National Institute for Clinical Excellence to assemble and disseminate good practice evidence.

Amidst the ongoing creation of new systems of state control over the medical profession, arguably the greatest state scrutiny arose from the case of two heart surgeons working at Bristol Infirmary. Found guilty of serious professional misconduct after the deaths of 15 small children in 1997, the government capitalized on the case to increase scrutiny in the NHS without medical opposition. As well as the huge media attention, the Government launched a public inquiry into the case, creating an atmosphere in which the medical profession were pushed into accepting a much higher degree of government control than ever before in the NHS. Clinical audit, where the outcomes of treatment were monitored, was made compulsory.¹¹⁸ In 1999, trust in the profession was further shaken when GP Harold Shipman was accused of mass-murdering his patients over a long period.¹¹⁹

Although government attention fell directly on the public sector, the increased pressure on the GMC also increased surveillance of *all* doctors. By the end of the twentieth century, medical regulation looked quite different to 30 years earlier: the President of the GMC himself was calling for a more active approach to self-regulation and the medical Royal Colleges had accepted regular competence testing of consultants. Klein concluded 'collegial control over the performance of

¹¹⁷ R. Klein, (2001) *op. cit.*, pp.180-181.

¹¹⁸ *Ibid.* p.210.

¹¹⁹ Staff and Agencies, 'Harold Shipman: a chronology', *The Guardian*, (July 15, 2004), www.guardian.co.uk/archive.

doctors had largely been maintained but at the cost of sacrificing the autonomy of individual doctors.⁹

Wider Drug Policies

In 1985, the first comprehensive drug strategy *Tackling Drug Misuse* was published by the Conservative Government.¹²⁰ This new development signalled increased political interest and Stimson has claimed that this act politicised drug strategy in a new way,¹²¹ but when the subsequent Labour Government published its ten-year drug strategy, *Tackling Drugs Together to Build a Better Britain*, modelling its title on the Conservatives' 1995 *Tackling Drugs Together*,¹²² it demonstrated continuity with its predecessor and a cross-party consensus.

The appointment to the newly created post of 'Drug Czar' of the former Chief Constable of West Yorkshire, Keith Hellawell, was seen as part of the penal approach to drug policy dating from 1997.¹²³ However, his deputy, Mike Trace, had extensive experience in drug treatment services. Hellawell then published an annual report with performance targets for the next decade, for instance the reduction of the number of people under 25 using heroin and crack cocaine by a quarter within 5 years and by a half within 10 years. Such targets drew criticisms from a number of sources as unmeasurable by existing mechanisms,¹²⁴ but were quietly abandoned, as was, though more noisily, the Drug Czar himself. The 1998 drugs strategy also departed from its predecessors by concentrating policy on heroin and cocaine as the drugs causing the greatest harm, and by hailing health interventions as the most effective way of reducing offending behaviour over and above penal solutions.

Those who have passed judgement on the 1990s have tended to emphasise continuity over change.^{125,126} Perhaps because they have considered drug policy as a whole, rather than focusing on treatment services, any move away from harm reduction rhetoric and greater use of coercion in

¹²⁰ Lord Privy Council, *Tackling Drug Misuse: A Summary of the Government's Strategy* (London: HMSO, 1985).

¹²¹ G. V. Stimson, (1987) *op. cit.*, pp.483-484.

¹²² Lord President of the Council and Leader of the House of Commons, Secretary of State for the Home Department, Secretary of State, *et al.*, *Tackling Drugs Together: A Strategy for England 1995-1998* (London: HMSO, 1995).

¹²³ G. V. Stimson, (2000) *op. cit.*, p.260.

¹²⁴ eg Working Party of the Royal College of Psychiatrists and the Royal College of Physicians, (2000) *op. cit.*, p.258.

¹²⁵ N. South, 'Tackling drug control in Britain: from Sir Malcolm Delevingne to the new drugs strategy' in R. Coomber (ed.), *The Control of Drugs and Drug Users: Reason or Reaction?* (Amsterdam: Harwood Academic Publishers, 1998) pp.87-106.

¹²⁶ S. MacGregor, 'Pragmatism or principle? continuity and change in the British approach to treatment and control' in R. Coomber (1998) *op. cit.*, pp.131-154.

treatment were marked as less significant than in the work of Stimson.¹²⁷ Though Nigel South acknowledged a punitive approach in both rhetoric and legislation, he saw inconsistency in policies across Britain, with Scottish policy documents strongly endorsing harm reduction. Labour's concerns about the role of 'social exclusion' as a factor in drug use were seen by both Rowdy Yates, a harm reduction activist, and Geoffrey Pearson, a criminologist and sociologist, as a significant change during the late 1990s,^{128,129} but what impact this had in practical policy terms was unclear. Both authors also considered the emergence of ecstasy and the widespread dance drug phenomenon of the late 1980s and 1990s as a major development, which Yates claimed had 'made existing drug treatment services almost irrelevant.'

How treatment policy was formulated, 1970-99

The drug policy community and the policy-making process have been considered primarily by Stimson and Lart, Berridge, Smart, Duke and MacGregor.^{130,131,132,133,134} Sociologists Stimson and Lart noted the traditions of British policy making which continued into the 1970s, reached through committees where debate was characterised by politeness and an absence of politics. Policy was made in private through accommodation between experts and civil servants, as exemplified by ACMD, set up in 1971. Berridge's account of the development of AIDS policy during the 1980s, although involving much more media attention, and a greater variety of outside groups, had similar components, being privately formulated between bureaucrats and outside interests and experts.¹³⁵ While doctors were not the chief architects of policy, as they were with the second Brain Report, key members of the profession, particularly medical civil servants like Dorothy Black, and psychiatrists like John Strang, were very influential.

Agreement has emerged about the declining centrality of medicine in response to drugs problems. The growth of new drug agencies following the Central Funding Initiative drew many new occupational groups into working with drug users, diversifying the policy community in the 1980s, and displacing the purely medical perspective on drug use and users.¹³⁶ Responses to drugs in the

¹²⁷ eg G. V. Stimson, (2000) *op. cit.*, pp.259-264.

¹²⁸ R. Yates, 'A brief history of British drug policy, 1950-2001', *Drugs: Education, Prevention and Policy*, 9 (2002), 113-124.

¹²⁹ G. Pearson, 'Drugs at the end of the century', *British Journal of Criminology*, 39 (1999), pp.477-487.

¹³⁰ eg. G. V. Stimson and R. Lart, (1994) *op. cit.*, pp.331-341.

¹³¹ eg. V. Berridge, (1993) *op. cit.*, pp.135-156.

¹³² eg. C. Smart, 'Social policy and drug addiction: a critical study of policy development', *British Journal of Addiction*, 79 (1984), 31-39.

¹³³ eg. K. Duke, (2003) *op. cit.*

¹³⁴ eg. S. MacGregor, (1998) *op. cit.*, pp.131-154.

¹³⁵ V. Berridge, (1996) *op. cit.*

¹³⁶ eg. V. Berridge, (1993) *op. cit.*, pp.139-143.

late 1980s included a more prominent place for government, the criminal justice system, and the community with medicine taking an important but less central role.¹³⁷

In a departure from the earlier 'gentlemanly' period of policy-making, Stimson saw the late 1980s as a time of politicisation. The establishment of the Ministerial Group on the Misuse of Drugs, for instance, showed that drugs were moving out of professional and advisory committees and that debate was becoming more public.¹³⁸ Linked to this politicisation was a huge rift between the 'political' and 'policy' community view of drugs, exemplified by the controversy over the Conservative Government's mass media anti-heroin campaign in 1985-86. Going against 'expert' advice from the drugs policy field, including that of the ACMD which opposed widespread publicity not part of an overall educational approach,¹³⁹ the publicity materials told people 'Heroin Screws You Up'. The aim was to eradicate rather than reduce the harm from use. The government commissioned its own evaluation of the campaign that gave it positive results, but the methodology was also criticized by the policy community.¹⁴⁰ Undeterred, in 1987 the Government launched another campaign with the message 'Don't Inject AIDS'. These events corresponded with anthropologist Susanne MacGregor's picture of a British approach to policy developing from debate among a limited range of 'well-informed interest groups', which shared a basic consensus. This process would occasionally be interrupted by intervention from politicians seeking to gain political capital from taking up drug issues.¹⁴¹

Hervé Hudebine, examining both national policies and local drug services in London in the last 15 years of the century, described the policy process as existing at a number of levels simultaneously, with gaps between the levels of national political rhetoric, policy resulting from civil servants and local agencies. A complex process appeared to be at work in the drug policy community, involving various understandings, tolerance and flexibility and acceptable degrees of confrontation and challenge born of mutual dependence between government and the various agencies. This allowed some degree of coexistence within the apparent policy contradictions of the different levels.¹⁴²

After varying degrees of enthusiasm and reluctance from different agencies, Hudebine saw harm reduction as becoming institutionalised in London between 1989 and 1993, with needle exchanges

¹³⁷ G. V. Stimson, (1987) *op. cit.*, p. 481.

¹³⁸ *Ibid.* p. 484.

¹³⁹ R. Power, 'Drugs and the media: prevention campaigns and television', S. MacGregor, (1989) *op. cit.*, pp. 129-142.

¹⁴⁰ *Ibid.* pp. 133-134.

¹⁴¹ S. MacGregor, (1998) *op. cit.*

¹⁴² H. Hudebine, (forthcoming) *op. cit.*

in voluntary services and pharmacies, collaboration between GPs and street agencies, provision of condoms, and so on.¹⁴³ This was then followed by harm reduction becoming more contentious once again in the political rhetoric and it had fallen to the lowest ranking policy goal of the White Paper *Tackling Drugs Together* in 1995.¹⁴⁴

Conclusion

This background sketch of the last three decades of the twentieth century has shown a period of turbulent change in both drug use and the policy responses to it. A widening range of people have become involved in taking illicit drugs, in commenting upon drug use, and in providing services. The policy process has moved from being mainly conducted in private, to an often public and more overtly political one and while there was no disagreement about the ubiquity of drugs at the end of the century, the extent to which their use has become 'normal' has remained contentious.

¹⁴³ *Ibid.*

¹⁴⁴ *Ibid.*

Chapter 3

Major Policy Change:

The *Treatment and Rehabilitation* Report (1982)

Introduction

The issue of private doctors prescribing to drug using patients was to be central to the controls considered and partially implemented in the early 1980s. Measures proposed in 1982 in the report *Treatment and Rehabilitation*,¹ potentially affecting the prescribing of around 30,000 GPs and other doctors, were greatly influenced by the emerging dispute between the small number of private prescribers and NHS Clinic psychiatrists in London.

Treatment and Rehabilitation was the first policy document to lead treatment services out of the hospitals and into the community after the centralisation of drug treatment into the Clinics in the late 1960s. It also outlined a role for voluntary services, and saw them as an important part of the multi-disciplinary response, praising their 'problem oriented approach' in contrast to the substance based approach of the Clinics.² Overshadowed by this wider impact, the report's significance for private doctors has been largely overlooked.

The policy-making process here and with the 'good practice' guidelines, which are discussed in the next chapter, was centred around the 'expert committee', continuing a pattern in the drugs field of the 1960s and early 1970s where decisions were reached through committees, in private, through accommodation between experts and civil servants.³ Published research evidence played a minimal role, with the emphasis rather on the authority, integrity and non-partisan approach of the committee members. However, in a politicised and polarised field this proved problematic.

Background and Context

Treatment goals for drug users oscillated after the establishment of the Clinics with renewed conflict within the medical profession regarding appropriate treatment. Particularly contentious was the issue of prescribing for opiate addicts, the main users of England's drug treatment services then

¹ ACMD, *Treatment and Rehabilitation*, DHSS, (London: HMSO, 1982).

² *Ibid.* pp.46-47.

³ G. V. Simson and R. Lart, 'The Relationship Between the State and Local Practice in the Development of National Policy on Drugs between 1920 and 1990', in J. Strang and M. Gossop (eds), *Heroin Addiction And Drug Policy: The British System* (Oxford, New York, Tokyo, Oxford University Press, 1994) pp.331-341, p.336.

and now. Prescribing styles advocated ranged between two extremes of 'maintenance prescribing', with drug users stabilised on a long term opioid prescription in the hope that this would enable them to focus on other aspects of their lifestyle and improve their health. At the other end of the treatment spectrum, abstinence was the most important goal with reducing doses of the drug prescribed over a short period to achieve detoxification. Prescribing debates also concerned the type of substitute opioids, whether heroin or methadone, their formulation as oral or injectable, and the appropriate doses. Concern about HIV/AIDS did not significantly permeate British drugs policy until 1985,⁴ and will be discussed in greater detail in later chapters.

When they opened in the late 1960s, the Clinics were offering mainly maintenance heroin prescribing, and some injectable methadone. Although the Home Office licences to prescribe heroin had almost entirely been restricted to psychiatrists running the Clinics, their services voluntarily moved away from this practice at the end of the 1970s. New practices favoured methadone instead of heroin, and then oral rather than injectable formulations. Instead of maintenance prescribing, the Clinics instigated a limited stabilisation period on a fixed dose that was then progressively cut to zero, often with a contractual obligation to attend for therapy.⁵

When the Clinics were being set up, a leading Clinic psychiatrist described as one of the rationales of the new approach the expectation that 'regular contact between the addict and the doctor of the centre gives the opportunity for a relationship to build up which may eventually lead to the addict requesting to be taken off the drug'.⁶ But this optimism may have been misplaced and by 1975, the Department of Health and Social Security was observing that, 'A pool of addicts on long-term maintenance who are unwilling to try to break their dependence on drugs has built up in the years since the present system was introduced in 1968'.⁷ A new approach was sought by clinicians and by the time *Treatment and Rehabilitation* was published, most of the London Clinics were offering only oral methadone detoxification to new opiate addicted patients without the option of longer term prescriptions or injectable drugs. While treatment had become more uniform in the Clinics, doctors outside, both NHS and private, were not so easily influenced. Conflict emerged between

⁴ V. Beccridge, *AIDS in the UK. The Making of Policy, 1981-1994* (Oxford: Oxford University Press, 1996) pp.90-93.

⁵ M. Mirccheson, 'Drug Clinics in the 1970s', in J. Strang and M. Gossop (eds), *Heroin Addiction And Drug Policy: The British System* (Oxford, New York, Tokyo, Oxford University Press, 1994) pp.179-191.

⁶ P. H. Connell, 'Drug dependence in Great Britain: a challenge to the practice of medicine' in H. Steinberg (ed.), *Scientific Basis of Drug Dependence*, Coordinating Committee for Symposia on Drug Action, (London: J&A Churchill, 1969) pp.291-299, p.293.

⁷ DHSS, *Better Services for the Mentally Ill* (London: HMSO, 1975) p.67.

those inside and outside the Clinics with published attacks on private prescribers appearing in medical journals from 1980 onwards.⁸

Origins and Purpose

The *Treatment and Rehabilitation* report (known for short as *T&R*) emerged after a very long gestation period (1975-82). It was the second of two reports prepared by a Working Group of the Advisory Council on the Misuse of Drugs, an independent body set up in 1971 under the Misuse of Drugs Act, to advise government. Its secretariat was usually provided by the Home Office, but where a subject had particular relevance to health or social services, it could be provided by that department. *T&R*, the Working Group's final report, was preceded in 1977 by an interim report.⁹ The changing membership of the Treatment and Rehabilitation Working Group is given in Table 3.1.

The Treatment and Rehabilitation Working Group's original task, in 1975, was 'to undertake a comprehensive review of the treatment and rehabilitation services for drug misusers and to make recommendations for dealing with both immediate problems and the situation generally'.¹⁰ The interim report gave several reasons for its concerns in 1977, but it is uncertain whether these formed the original motivation for their investigations in 1975. The introduction described 'a continuing, serious and slowly worsening problem' of which the authorities seemed unaware: overloaded London Clinics, increasing multiple drug use for which there were insufficient treatment places, and also a limited choice in rehabilitation facilities.¹¹ David Turner recalled that the Working Group was established very early on in the life of the Council, before there was any pressure for action from outside the Council. At the time it was particularly concerned about the level of barbiturate injecting and overdoses.^{12,13} It seemed likely that some of these concerns would have emerged during the Working Group's research but because most of the ACMD's minutes were covered by the Official Secrets Act, further investigation into the reasons for setting up the group are unknown.

The Treatment and Rehabilitation Working Group's secretariat was provided by the Home Office but in 1976 its chairman, Arthur Blenkinsop, suggested it be transferred to the Department of Health and Social Security (DHSS). According to one account,¹⁴ Mr Blenkinsop and at least one

⁸ eg. T. H. Bewley, 'Prescribing psychoactive drugs to addicts', *British Medical Journal*, 281 (1980), 497-498.

⁹ ACMD, Treatment and Rehabilitation Working Group, *First Interim Report* (London: DHSS, 1977).

¹⁰ *Ibid.* p.2.

¹¹ *Ibid.* p.3.

¹² D. Turner [SCODA], (2003) *op. cit.*

¹³ DHSS, (1975) *op. cit.*, p.69.

other member felt it was inappropriate for the Home Office to take an active role in the treatment of drug dependence and believed that there should be a clear separation between treatment, the usual domain of the DHSS, and criminal jurisdiction, the responsibility of the Home Office.

Although both the interim and final reports were published under the imprimatur of the DHSS, a formal transfer of secretariat does not seem to have occurred. The interim report listed only two secretariat members at the time of reporting, both from the Home Office. While officials from both ministries attended the Working Group's meetings, a lengthy correspondence between DHSS civil servants made clear their reluctance to accede to the Chairman's wishes and take over the formal secretariat role and their belief that the Home Office was equally unwilling to relinquish it.¹⁵ The DHSS officials were amenable to being more involved in the Working Group, particularly by providing a wider range of professional advisors to the committee, but falling short of taking on the secretariat's role. Christopher Ralph, a DHSS civil servant, considered the Home Office's distance from the details of treatment services to have been beneficial to the Working Group's research and the DHSS 'always preferred to keep its distance from the Council'.¹⁶ He took the view that by having a Home Office secretariat, staff in treatment services had felt able to give more detailed responses to committee members' questions on priorities and budget reviews than they might had the secretariat been provided by the DHSS. He also referred to potential conflicts with other related policy work DHSS staff were involved in and the additional workload involved. The DHSS's previous experience of Mr Blenkinsop's heavy reliance on their secretariat also seems to have deterred them. In June 1976, the DHSS's Dr Alan Sippert recorded agreement between himself, the Home Office Working Group secretary Mr D. G. Turner¹⁷ and the chairman Mr Blenkinsop that the Home Office would continue to provide the Working Group's secretariat but that Dr Sippert would attend the meetings regularly.¹⁸ The preserved notes gave the impression of agreement and perhaps collusion between the two departments to keep the Working Group where they wanted it.¹⁹

The first Working Group, responsible for the interim report, gathered oral and written evidence. Some of its members made site visits, which included health authorities in London and Newcastle where they met an accident and emergency doctor, psychiatrists, other hospital staff involved in

¹⁴ D. Turner [SCODA], Personal communication, (2003).

¹⁵ DHSS Minutes, (25th May 1976-7th June 1976), File D/A242/12B, DH Archive, Nelson, Lancashire.

¹⁶ D. Turner [SCODA], (2003) *op. cit.*

¹⁷ Mr D G Turner was secretary to the Working Group and should not to be confused with Mr David Turner, Co-ordinator of the Standing Conference on Drug Abuse, representing voluntary drug services.

¹⁸ A. Sippert, DHSS Minute, (17th June 1976), File D/A242/12B, DH Archive, Nelson, Lancashire.

¹⁹ DHSS Minutes, (25th May 1976-7th June 1976), File D/A242/12B, DH Archive, Nelson, Lancashire.

treating drug users, police and probation officers, and representatives from social services and local voluntary agencies. Oral evidence was received by the Working Group from the chairman of a London health authority Drug Misuse Liaison Committee, Sister Beaurepaire (an A&E nurse who was to become a member of the next Treatment and Rehabilitation Working Group), an A&E consultant, a probation officer, members of the prison service including medical officers, Dr Martin Mitcheson (a London DDU psychiatrist) and Dr Hamid Ghodse (a psychiatrist colleague and collaborator of Working Group member Dr Thomas Bewley, both of whom were at St Thomas' Hospital DDU). Also giving oral evidence were a consultant psychiatrist and probation officer from Norwich and three representatives of voluntary organisations. The sources of its written evidence were not described.

Although interviewees were overwhelmingly medical, the wider range of site visits suggested that this first Working Group was looking beyond a medical response, perhaps foreshadowing the second Working Group's emphasis on the multi-disciplinary model. The committee did not reveal how these sources of evidence were selected, with the exception of individuals from specialist services who were proposed by one member, Dr Bewley.

Membership

The selection of members showed both continuity with and change from the past. While the mix of 'experts' and concerned, well-connected citizens typified earlier policy-making styles in the drugs field (see Table 3.1), its multi-disciplinary approach was a departure from the all-medical Brain Committees of the 1960s. The Working Group had a strong London bias, perhaps to be expected as drug services (and drug use) had been centred in London for several decades, although this was beginning to change (see Chapter 2).

This first group included a social work advisor on drug problems based in London, a nurse specialist, a worker at a London Citizens Advice Bureau (also married to a prominent social scientist with a hereditary title), a London consultant psychiatrist and head of a Clinic, a fellow of an Oxford college, and the head of the Standing Conference on Drug Abuse (SCODA), representing the voluntary sector. The Working Group's chairman was the Labour Member of Parliament for South Shields in the North of England. In total four had expertise in the drugs field and three were lay members of the ACMID. No one from general practice was represented, neither was oral evidence taken from GPs, features that changed on the second Working Group. The emphasis of the interim report was on the Clinics and accident and emergency services; primary care had little role in drug treatment at this stage.

Table 3.1 Membership of the Treatment and Rehabilitation Working Group, 1975-82

Working Group from 1975 (responsible for the interim report ²⁰)	Working Group from 1978 (responsible for the final report ²¹)	Description
Mr Arthur Blenkinsop (Chairman)		Member of Parliament for South Shields, Labour.
Dr Thomas H Bewley	Dr Thomas H Bewley	Consultant Psychiatrist, St Thomas' Hospital, London
Miss Annas Dixon	Miss Annas Dixon	Social Work Advisor on Drug Problems. Camden Social Services (until September 1979) Then freelance consultant and lecturer on drugs
Mrs Jennifer Hart		Academic, fellow of a college of Oxford University.
Rev E Lewis	Rev E Lewis (until December 1980)	Area Nurse Specialist
Mrs Ruth Runciman	Mrs Ruth Runciman	Citizen's Advice Bureau, Hackney
Mr R E Searchfield		Head of SCODA
	Prof R Duckworth (Chairman)	Prof of Oral Medicine, London Hospital Medical College
	Miss F Adamson	Lecturer in Social Work
	Sister B Beaupaire (until her death in 1979)	Nurse, A&E, St Thomas' Hospital London.
	Dr Philip Connell (from November 1981)	Director, Drug Dependence Clinical Research and Treatment Unit, Maudsley, London. Consultant Psychiatrist
	Mr A Gorst	Director of Social Services, London Borough of Barnet
	Prof H Gwynne-Jones (member Oct 78-June 81)	Dept of Psychology, Leeds University.
	Dr G Mathers	GP, Gloucester, Police Surgeon
	Dr D J Parr (member	Consultant Psychiatrist, Brighton

²⁰ ACMD, Treatment and Rehabilitation Working Group (1977) *op. cit.*

²¹ ACMD, (1982) *op. cit.*

	from November 1978)	Health District
	Mr S Ratcliffe (member from May 1981)	Probation Officer, London
	Mrs M Sharpe (member from Sept 1979)	Sister, University College Hospital DDU
	Dr Anthony P Thorley	Consultant Psychiatrist, Newcastle (Director, Alcohol and Drugs DDU)
	Mr D Tomlinson (member from October 1978)	Executive Director, Phoenix House.
	Mr D Wild	Regional Medical Officer, South West Thames RHA
	Professor Sir Robert Bradlaw (member until December 1980, retired)	Chairman of ACMD 'ex officio member'
	Mr David Turner	Co-ordinator, Standing Conference on Drug Abuse
Secretariat		
Mr D G Turner	Mr D G Turner (until 1980)	Committee Secretary, Home Office
Mrs M J Taylor		Assistant Committee Secretary, Home Office
	Mr D J Hardwick	Secretary of the ACMD
Assisted by		
	Miss C Le Poer French	
	Mr N Shackleford	
	Mrs C Heald	
	Miss K Albiston	
	Mr R G Yates	

Table 3.1 shows the extent to which the second Working Group grew, gaining much wider drugs expertise and geographical spread. The second Working Group gained three more psychiatrists, a general practitioner and a new chairman. No private practitioners were members, but oral evidence was taken from them. Only four of the original seven members remained on the second committee, which swelled to nineteen, although not simultaneously; the secretary left in 1980 and

the assistant secretary did not continue on after the interim report was published. *T&R* listed seven secretariat members, not to mention the twenty-six officials who were also involved. The reasons for this seem to have been its new remit, the new perceived urgency of the situation facing drug treatment services, and changes in the three-yearly membership of the ACMD itself, from whom most of the Working Group members were drawn.²²

In July 1978, nearly a year after the interim report's publication, the Working Group agreed its new brief as being 'to examine the range of services available for those who suffered harm through their drug misuse; consider whether this was sufficiently flexible to the needs of the individual and suggest ways in which the combined response could be improved.'²³ In order for the Working Group to fulfil this task, it seems likely that it considered that it needed representatives from all the agencies between which coordination was desired. David Turner, the co-ordinator of SCODA, also drew the new second Working Group's attention to the question of how adequate information could be obtained regarding the situation outside London,²⁴ which was in part answered by expanding the membership.²⁵

Findings of the first Treatment and Rehabilitation Working Group (1977)²⁶

One would expect an interim report to be more cautious, as its conclusions were not final, and this was certainly the case, proposing retention of the existing system until reviews had taken place and further research. It also laid the ground for some of the recommendations taken further in the final report, including its view that 'a multi-disciplinary approach to the problem of drug misuse is essential', and recommended:

- (i) A review of the notification procedure for the Home Office's Addicts Index to improve the quality of data collected (also considered by *T&R*, paras 6.20-6.21, concluding that the data should be made more widely available)
- (ii) No Clinic closures before a full review (*T&R* maintained an important role for Clinics and set minimum staffing and service levels in Chapter 6)
- (iii) Provision of services for multiple drug users (also recommended in *T&R*)
- (iv) Closer working between Clinics, social services and voluntary organisations (a major concern of *T&R*, and remit of the second Working Group, which envisaged this could be achieved through a new framework of committees.)

²² D. Turner [SCODA], Personal communication, (2003).

²³ D. Turner [SCODA], TRWG (2)/20 'Treatment and Rehabilitation Working Group', (16th November 1978), File D/A242/12, DH Archive, Nelson, Lancashire.

²⁴ *Ibid.*

²⁵ D. Turner [SCODA], (2003) *op. cit.*

²⁶ ACMD, Treatment and Rehabilitation Working Group, (1977) *op. cit.*, pp.6-18.

- (v) A new role for specialists in educating GPs and others involved in treatment. (*T&R* found severe shortcomings in training and made recommendations for major changes).
- (vi) Further research into the role and effectiveness of treatment (these were repeated and extended in *T&R*'s Chapter 8)

The *Interim Report* did not discuss the form treatment itself should take, and avoided tackling the sensitive issue of substitute prescribing, saying 'We recognise that there is considerable uncertainty about effective methods of treatment for drug misusers and we avoid making specific recommendations which might seem to limit innovation'.²⁷

The Second Working Group

In the light of the second Working Group's broad remit, agreed in July 1978, David Turner, who had replaced Bob Searchfield on the ACMD as representative of SCODA, was asked to identify specific areas for consideration taking into account the responses to the interim report. The report had been circulated to Area and Regional Health Authorities, social services authorities and professional and voluntary organisations. Health Authorities were relied upon to coordinate the responses in their local areas, including those from Clinics. The resulting paper signed off by David Turner made some radical proposals against a background of Home Office statistics and responses to the report that apparently confirmed the interim report's view of a 'serious and slowly worsening problem'.²⁸

In addition to some simple tidying suggestions, like producing a clear definition of 'multiple drug takers', David Turner also drew attention to the need for information about the situation outside London. Then, marked as a 'major dilemma' raised in responses to the first report, he pointed to Clinics' varying prescribing policies, with particular contrasts between those in London and those outside, and came to the radical conclusion that, 'The role of the treatment service (DDC)²⁹ as both a treatment system and as a means of control both of the supply of drugs to dependent persons and of the spread of addiction is no longer viable, if it ever was'.³⁰

David Turner concluded by suggesting two alternatives to the Working Group: adapting the present structure to make services available to a wider group of patients or proposing an alternative

²⁷ *Ibid.* p.8.

²⁸ D. Turner [SCODA], TRWG (2)/20 'Treatment and Rehabilitation Working Group', (16th November 1978), File D/A242/12, DH Archive, Nelson, Lancashire.

²⁹ DDC stands for 'drug dependence clinic' and is interchangeable with DDU or 'Clinic'.

³⁰ D. Turner [SCODA], (16th November 1978), *op. cit.*

model for the provision of services 'which is not based upon the substance misused but the social, medical, personal, etc problems facing the individual'.¹¹ Given the tone of the paper and preceding justification, much greater weight went behind these second of the two options. Thus a non-medical member was questioning the value of the dominant medical system and laying the ground for a new phase in drug treatment policy.

Findings of the final *Treatment and Rehabilitation Report* (1982)

T&R was published with the full approval of the ACMD which added weight to its recommendations. The report was divided into eleven chapters. The first described the original task, interim report, the broadening of the remit since the earlier report and scope of *T&R*. Chapter 2 considered the historical background going back to the legislative controls on drugs and the Rolleston report of the 1920s, the conclusions of which formed the basis for treatment and rehabilitation policies until the 1960s, followed by the first and second Brain Committees and the subsequent Clinic and notification systems under consideration by both the Working Groups. The legislative framework, particularly important to set the scene for Chapter 7's proposed modifications, was outlined.

Discussion of existing treatment and rehabilitation services and their 'effectiveness' according to research took a detached view, not favouring any particular approach. Trends in drug use since the 1960s that were seen as significant were multiple drug use, the high prevalence of barbiturate and other tranquilliser misuse, the increase in the proportion of new heroin addicts in the numbers being notified to the Addicts Index and the drop in the age of drug users. It also described an increase in the proportion of addicts being notified to the Addicts Index (ie presenting for treatment and being found dependent on opiates or cocaine) from outside the Clinics, and possible reasons why drug users might be turning away from the Clinics and towards private practice or NHS GPs.

Later on, the report suggested that, particularly where there was no prospect of an addict becoming abstinent, curbs on prescribing by the Clinics might have encouraged drug users to seek treatment from GPs and private prescribers in order to obtain prescriptions. A new concept was also introduced: the 'problem drug taker', which replaced the 'drug addict', and was intended to encourage a 'problem oriented rather than specifically client or substance labelled' approach.¹²

¹¹ *Ibid.*

¹² ACMD, (1982) *op. cit.*, p.34.

The report then went on to propose local and national structures to provide the services it envisioned. Regional health authorities were to assess the extent of problem drug use and services in their region and make arrangements to meet perceived needs, recommending the establishment of a multi-disciplinary regional drug problem teams to help with this process. The team's ambitious workload would include running the specialist service and providing support to doctors outside the Clinics. At district level, drug advisory committees would be set up to monitor problem drug taking in their districts, assess service effectiveness, propose improvements and generally improve coordination between agencies. It then described the roles for the statutory and non-statutory specialist services, and non-specialist services, laying down minimum responsibilities for the Clinics and observing that 'During the visits to selected areas and in discussions with those working in treatment centres, it was noted that many clinics fall far short of the above minimum standards'.³³

Chapter 7 of the report proposed extensive curbs on prescribing by 'doctors working away from the hospital-based specialist services' ie NHS GPs and private prescribers treating drug users. The chapter was most particularly concerned by 'a marked increase in private prescribing to problem drug takers, particularly in London, exemplified by three doctors in private practice who contributed over 10 per cent of all notifications to the Home Office during the nine months January to September 1980'.³⁴

The rise in treatment outside the Clinics worried the Working Group for four reasons. These were a 'Lack of specialised knowledge, training and experience' essential for working in 'this difficult area';³⁵ the dispensing of drugs less often than daily and thus increasing the likelihood of supplies being diverted to the black market and of drug users taking more than their daily dose at once and overdosing; pressure from patients on vulnerable doctors to prescribe drugs was listed as a worry, with uncited 'evidence of doctors issuing prescriptions simply to get rid of threatening patients' and finally the lack of 'easy access to the support staff' and facilities that were available to doctors in some hospital-based Clinics.³⁶

These apparently created two major problems: liberal prescribing was attracting patients away from the Clinics to obtain larger doses of drugs from other doctors, which could increase their dependence and it was increasing the amount of legally manufactured drugs available in the illegal market as patients sold their surplus. Although it stated that 'problems arise whether the doctor

³³ *Ibid.* p.45.

³⁴ *Ibid.* pp.51-62.

³⁵ *Ibid.* p.52.

³⁶ *Ibid.* pp.52-53.

provides treatment under the National Health Service or privately', *T&R* went on to vehemently attack private prescribing, even questioning whether a therapeutic relationship could develop when fees were involved.³⁷ It found existing regulatory mechanisms inadequate, remarking that private prescribing of controlled drugs to problem drug takers was 'undesirable' because there were 'moral and ethical aspects which cannot easily be dealt with by the General Medical Council and give grave cause for concern.' There was suspicion as to how mostly unemployed patients could pay for treatment without selling a proportion of their prescribed drugs on the black market, although no evidence was cited.³⁸

Three corrective measures were proposed: the preparation of 'good practice' prescribing guidelines by a medical working group; the extension of Home Office licensing from heroin and cocaine to all opioid drugs, with urgent action being taken on dipipanone,³⁹ and changes to the Home Office tribunal system so that it addressed a wider range of 'irresponsible prescribing'. This last recommendation may have been suggested by the Home Office Drugs Inspectorate,⁴⁰ representatives of which were present at the Working Group's meetings. Bing Spear, then Chief Drugs Inspector, later expressed his agreement with the report's criticism that the Home Office had under used the tribunal system.⁴¹ Home Office tribunals are discussed in detail in Chapter 6. The licensing extension would have meant that instead of only heroin and cocaine prescription for the treatment of addiction being restricted to doctors holding a special Home Office licence, the prescribing of additional drugs would be limited to licence-holders.

Great deficiencies were found in training provision, both among those already working with drug users and those whose jobs might lead them into contact with them in the future, and recommendations to remedy this were made. Chapter 9 made a brief exploration of the difficulties of conducting research in this area, defining and assessing success in treatment and rehabilitation and the lack of research evidence, recommending areas needed to inform service development.

T&R described shortcomings of the existing Clinic system in the face of increasing demand and altered patterns of recorded drug use. Alternatives to expanding treatment were briefly considered and rejected, including ending prescribing entirely and leaving most aspects of drug misuse to the

³⁷ *Ibid.* p. 54.

³⁸ *Ibid.* p. 54.

³⁹ Dipipanone combined with the anti-nausea drug cyclizine was marketed as *Diconal* and had been widely illicitly used in the North of England.

⁴⁰ A. Thorley, Interview by Sarah Mars, (2002).

⁴¹ H. B. Spear (and ed. J. Mott), *Heroin Addiction Care and Control: The 'British System' 1916-1984* (London: DrugScope, 2002) p. 63.

control of the criminal justice system. A reversal of the existing policy that had excluded general practitioners from treatment was put forward as a solution.

General practice, already established throughout the country, offered a cheaper solution to extensive development of the Clinic system, although some hospital-based expansion was also recommended. To the Working Group, the involvement of GPs in treatment would enable wider geographical coverage and treatment for more drug users. But this also risked devolving prescribing decision-making away from the centre, justifying Chapter 7's three inter-connected measures to strengthen prescribing regulation. Yet these measures were less aimed at future developments in the re-involvement of GPs as at the existing situation in 1982: private doctors' perceived over-liberal prescribing and the black market in pharmaceutical drugs.⁴²

Significance

Since its publication in 1982, *T&R* has been defined as important in a number of ways. Its advocacy of integrating treatment and rehabilitation services through a multi-disciplinary approach involving health, social service, probation, education services, and the voluntary sector was widely seen as departure from existing policy,⁴³ but this was not a new idea. Closer cooperation had been recommended in the DHSS's 1975 White Paper *Better Services for the Mentally Ill*,⁴⁴ and by the Working Group's interim report.⁴⁵ *T&R*'s multi-disciplinary, integrating approach had also been touched on briefly by the second Brain Committee. Lord Brain's report had recommended that 'proper facilities for long-term rehabilitation, both physical and psychological, [should be provided] in the treatment centres and elsewhere'.⁴⁶ However, when the Clinics were established they did not incorporate rehabilitation facilities and the split between treatment and rehabilitation remained through the rest of the century.

Both *T&R* and the interim report showed many areas of continuity with *Better Services for the Mentally Ill*, and indeed many documents written in the 1970s: they described the apparent increase in multiple drug use unmatched by services, overburdened Clinics and the continuing drug use of long term users despite treatment. Both the interim report, the 1975 White Paper, and later *T&R*, advocated a 'multi-disciplinary' approach within Clinics, and between Clinics and other agencies, as

⁴² T. Bewley, Interview by Sarah Mars, (2001).

⁴³ S. MacGregor, 'Choices for policy and practice', in S MacGregor (ed.) *Drugs and British Society. Responses to a Social Problem in the 1980s* (London and New York: Routledge, 1989) pp.170-200.

⁴⁴ DHSS, *Better Services for the Mentally Ill* (London: HMSO, 1975).

⁴⁵ ACMD, Treatment and Rehabilitation Working Group, (1977) *op. cit.*, p.9.

⁴⁶ Interdepartmental Committee on Drug Addiction, *Drug Addiction. The Second Report of the Interdepartmental Committee* [second Brain Report], Ministry of Health, Scottish Home and Health Department, (London: HMSO, 1965) p.9.

did most of the policy documents that succeeded them, emphasising a wider approach to addiction beyond the medical into social rehabilitation.

Commentators have also given prominence to *TC&R*'s redefinition of the 'drug addict' as the 'problem drug taker'. Following a change of terminology in the alcohol field, it described problem drug takers as 'any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco).'⁴⁷, ⁴⁸ The Advisory Committee on Alcoholism had produced a report on the pattern and range of services for problem drinkers which was received by the second Working Group, in which the term 'alcoholic' was replaced with 'problem drinker'. Anthony Thorley, one of the four Clinic psychiatrists on the second Working Group, was impressed and considered its equivalent might usefully replace 'addict' as a non-medical term.^{49,50} It has been claimed that this eased the movement towards a more problem-oriented approach and away from a preoccupation with the particular substance being used.⁵¹

In conceptual terms, introducing the new term 'problem drug taker' seemed to recast the policy focus away from a disease based model to a broader viewpoint. Whether this took place in practice was harder to say. Furthermore, although a less narrowly medical model might seem to have reduced the potential role for medicine by necessitating input from the other professions and voluntary services, historian Betsy Thom has suggested that in the alcohol field this change also opened up new approaches for psychiatry,⁵² and it seems that a very similar effect could be seen in the drugs field, with psychiatry maintaining a dominant, if challenged, position.

The new term could be seen as both normalising and re-pathologising drug users: on the one hand it suggested that not all drug users had problems resulting from their drug use as 'the majority are relatively stable individuals who have more in common with the general population than with any essentially pathological sub-group'.⁵³ On the other it also stated that addiction was not the limit of

⁴⁷ ACMD, (1982) *op. cit.*, p.34.

⁴⁸ M. Plant, 'The epidemiology of illicit drug-use' in S MacGregor (ed.) *Drugs and British Society. Responses to a Social Problem in the 1980s* (London and New York: Routledge, 1989) pp.52-63.

⁴⁹ Home Office, TRWG Mins 23, Minutes of the 23rd Meeting of the Treatment and Rehabilitation Working Group, (27th November 1978), File D2/A242/12 Vol. G., DH Archive, Nelson, Lancashire.

⁵⁰ A. Thorley, Interview by Sarah Mars, (2002).

⁵¹ J. Strang, 'A model service: turning the generalist on to drugs' in S. MacGregor (ed.) *Drugs and British Society. Responses to a Social Problem in the 1980s* (London and New York: Routledge, 1989) pp.143-169.

⁵² B. Thom, *Dealing With Drink. Alcohol and Social Policy From Treatment to Management* (London and New York: Free Association Books, 1999) pp.105-134.

⁵³ ACMD, (1982) *op. cit.*, p.31.

drug problems that drug services, both medical and non-medical, might need to address, but should include regular excessive consumption and intoxication.

The Working Group's minutes showed that two of its psychiatrists were keen to put drug use into a wider context outside medicine,⁵⁴ and the report reflected this, arguing against the utility of the disease model: 'The problem drug taker seeking treatment may regard himself as having a disease or illness and may adopt a relatively passive sick role' which was 'inappropriate in the management of drug problems where clearly there is a volitional element, and personal responsibility and accountability are implicit.'⁵⁵

Also in common with *Better Services for the Mentally Ill*, there was a perception that drug services required central funding because in times of spending cut-backs, unpopular patient groups would be the first to suffer at the local level. This was repeated in *T&R*, won the support of Norman Fowler, and took form in the Central Funding Initiative (see Chapter 2).

Perhaps the reason that *T&R* has been credited with innovations that earlier policy documents had trailed, was that, unlike its forerunners, many of its recommendations were implemented. Its publication coincided with a time of considerable public and political concern about the rise in drug use, and the government implemented many of its recommendations. Dipipanone was swiftly added to the list of drugs for which doctors needed a Home Office licence to prescribe in the treatment of addiction; a medical working group was set up to draw up good practice guidelines; several million pounds were made available to develop drug services and GPs were officially encouraged to treat drug users with support from community drug teams.

Alternatively, its impact may have lain in the unquestionable novelty of re-involving the medical generalist,⁵⁶ albeit with strict controls, and bringing drug services out of the hospital setting.⁵⁷ Spear saw the report's emphasis on the multi-disciplinary approach beyond prescribing as heralding the end of the Clinic era and the dominance of hospital-based treatment services,⁵⁸ but this was probably over-stating the case, given the subsequent difficulties in recruiting GPs to take up the challenge.

⁵⁴ Home Office, 'TRWG Mins 23, Minutes of the 23rd Meeting of the Treatment and Rehabilitation Working Group, (27th November 1978), File D2/A242/12 Vol. G., DH Archive, Nelson, Lancashire.

⁵⁵ ACMD, (1982) *op. cit.*, p.35.

⁵⁶ J. Strang, 'The British System': past, present and future', *International Review of Psychiatry*, 1 (1989), 109-120.

⁵⁷ V. Berridge, 'Historical issues', in S. MacGregor (ed.) *Drugs and British Society. Responses to a Social Problem in the 1980s* (London and New York: Routledge, 1989) pp.20-35.

⁵⁸ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.276.

The most significant aspect of the report in the public-private debate was the raft of regulatory measures over prescribing *Treatment and Rehabilitation* recommended, most of which were implemented and had major significance for the clinical autonomy of doctors treating drug users. At the heart of this lay its heavy attack on private prescribers and the extensive measures recommended to control them and other doctors working outside hospital-based services (GPs). Few aside from Bing Spear noted the importance of this chapter, which he saw as an opportunity for 'the more politically motivated and forceful members' of the London Consultants Group (discussed in Chapter 8) 'to regain the influence they feared they were in danger of losing'.⁵⁹ Evidence examined in this study has supported Spear's argument.

Development 1975-82

Differences between the interim and final reports can be attributed in part to the changes in membership and to external developments. The interim report's relatively cautious recommendations may also have resulted from the first Working Group's lack of leadership: Mrs P A Lee, a DHSS civil servant wrote that 'Mr Blenkinsop himself is not a strong chairman with any marked capacity to guide his Committee'.⁶⁰ In addition he is said to have relied heavily on the secretariat for briefing before meetings rather than forming his own views and to have lacked a sense of direction.⁶¹

Developments outside the Working Group had a significant impact. Nineteen seventy-seven, when the interim report was published, could be described as the 'lull before the storm'. In launching the interim report, Roland Moyle, the then Minister of State for Health and Social Services, said, 'It does not appear that there has been the explosion of narcotic drug addiction which was feared at the time when the present drug clinics were set up'.⁶² Due to the length of time between collection and analysis by the Home Office, the figures available to Mr Moyle only reached 1975, and both the report, and resulting press statement, referred to a levelling off and even a slight fall in registered addicts. Yet even by the time of David Turner's briefing paper to the new Working Group,⁶³ it was clear that the trend had changed, and by 1982, the picture was transformed again (see Chapter 2 of the thesis). David Turner later recalled:

⁵⁹ *Ibid.* p.276.

⁶⁰ P. A. Lee, DHSS Minute, (25th May 1976), File D/A242/12B, DH Archive, Nelson, Lancashire.

⁶¹ *Ibid.*

⁶² DHSS, 'Press release', (26th September 1977) D2/A242/12 Vol G, DH Archive, Nelson, Lancashire.

⁶³ D. Turner [SCODA], 'TRWG (2)/20 'Treatment and Rehabilitation Working Group', (16th November 1978), File D/A242/12, DH Archive, Nelson, Lancashire.

*It was in 1978 or early 1979 that we issued a SCOD. A press release noting that there was a rapidly increasing number of young heroin smokers appearing at drug services and calling for an urgent response from the DHSS. This was confirmed by the notification figures for 1978 and 1979 and gave a much greater urgency to the work of the Group. Before it had been moving slowly with relatively little sense of urgency but this approach could no longer be sustained and both the DHSS and the Home Office recognised this.*⁶⁴

The new supply of cheap, trafficked heroin which had started coming into the country in the late 1970s replaced diverted pharmaceutical drugs as the main source of illicit supply, and, as David Turner remembered, this resulted in a dramatic increase in the number of notified addicts. There were also suggestions that even larger numbers were not coming forward for treatment. The increase in the availability of illicit drugs had also altered the relationship between doctors and the source of supply. While they could still offer treatment, changes in prescribing patterns could have minimal affect on the availability or price of illicit heroin and the role of the Clinics in controlling the drug supply was therefore significantly weakened (see Chapter 2).

In addition to the subsequent increase in drug users was the apparent rise in the number of doctors involved in treatment outside the Clinics, unsanctioned by either government policies or the British Medical Association. Figures from the Home Office's Addicts Index showed that the proportion of patients notified from general practice (but not specifying NHS or private) had risen from 15% in 1970 to 53% in 1981, constituting an absolute as well as relative increase. In 1977, when the involvement of private prescribers was uncontroversial, and possibly on a smaller scale, the interim report had confined itself to NHS services. The future report, it said, was to consider voluntary services, but no mention was made of private prescribers. As central government became more sensitive to drugs issues, the DHSS sent more staff to attend the Working Group's meetings, aware that it was about to become a political issue (see Table 3.1).⁶⁵

The Final *Treatment and Rehabilitation* Report (1982):

Safeguarding Centralised Control

Although the report recommended a reversal of the policy that had discouraged GPs from involvement in this field since the late 1960s, and criticised the ability of the Clinics to meet demand, it held up hospital-based services as the theoretical ideal. Access to support staff such as nurses, social workers and psychologists and assessment facilities, although admittedly not

⁶⁴ D. Turner [SCODA], Personal communication, (2003).

⁶⁵ *Ibid.*

universally available in the Clinics, was seen as preferable, as well as the advantage of employing doctors within the 'structured system' of a hospital, which allowed restrictions to be imposed upon their prescribing by the consultant who took ultimate responsibility. However there was no mention of whether this had ever happened and the report did not consider the prescribing decisions of hospital consultants themselves, some of whom had no specialised knowledge in the treatment of drug misuse, but were simply general psychiatrists working on general psychiatric wards.

T&R considered it preferable for both NHS and private doctors working outside hospitals to liaise closely with hospital specialists and members of other disciplines in making their prescribing decisions. It also suggested that further knowledge could be gained by GPs taking up clinical assistantships in hospital-based services. Along with the other methods of surveillance and monitoring recommended by the Working Group, these proposals could have enabled control of the prescribed drug supply to have been taken along the lines favoured by the London NHS psychiatric establishment.

The two London consultant psychiatrist members of the T&R Working Group – Dr Bewley and Dr Connell – supported a policy of very restricted prescribing and opposed maintenance on opiates, especially outside the hospital setting. They favoured abstinence-oriented treatment over longer term prescribing, and methadone over heroin. The other two, Dr Parr and Dr Thorley, had been invited onto the Working Group at the end of 1978 by the medical civil servant Dr Sippert as 'permanent expert witnesses' due to their experience of treatment outside London (in Brighton and Newcastle respectively),⁶⁶ and, in the case of Dr Thorley, to counter-balance the London/South East dominance of the Group.⁶⁷ Dr Thorley, according to one member, was 'of a newer generation, more open to working with other people and other services and keener on the idea of multi-disciplinary working...he represented a different approach and one not always welcomed by his consultant colleagues on the Working Group.'⁶⁸

Thorley saw things similarly and contrasted his own approach with that of Thomas Bewley within the Group: 'The whole of the process was on the threshold of a, a rather different view looking at so-called drug addiction, which a number of us were quite keen in framing, sort of, new way of thinking. And he [Bewley] represented a kind of old school medical model, you know, in a very

⁶⁶ Home Office, TWG Mins 22. ACMD, 'Treatment and Rehabilitation Working Group', Meeting held on 2nd October 1978, File ID/A242/12, DH Archive, Nelson, Lancashire.

⁶⁷ D. Turner [SCODA], (2003) *op. cit.*

⁶⁸ *Ibid.*

clear and identifiable way.⁶⁹ Bewley was considered the most senior medical member of the committee, and in the highly stratified system of medicine this could have an inhibiting effect on other doctors on the Group.^{70,71} Dr Thorley explained,

[Dr Bewley] had a lot of personal influence, and power and so on. I mean he went on to take high office in the Royal College of Psychiatrists later, and so on and so forth, and he was very active on the General Medical Council. ... And, and so, you know, when you're just a young baby consultant coming along, and you've got somebody as senior as that in the medical kind of hierarchy, it's not easy to make a sort of, a, you know, start to initiate what was... a bit of a paradigm shift really.⁷²

Philip Connell had established his reputation with a study proving the previously unknown psychotic effects of amphetamine⁷³ and Thomas Bewley had been one of the first psychiatrists treating drug users in England during the 1960s.⁷⁴ Among psychiatrists around the London Clinics, there were a range of views on the wisdom of maintenance prescribing. However, those in the most powerful positions, including Dr Connell and Dr Bewley, seemed to have been successful in imposing their views on the majority of others at meetings of the London consultants held at the Home Office. They also took an interest in the regulation of the profession. Philip Connell was the Royal College of Psychiatrists' representative on the GMC from 1979, and Thomas Bewley replaced him in 1991.^{75,76} In 1980, Bewley had been responsible for the first published attack on private prescribing, suggesting that control of psychoactive drugs should be confined to licensed practitioners,⁷⁷ views repeated in *TeaR* and a few years later he reported Ann Dally, a well known private prescriber, to the GMC.^{78,79}

Both Connell and Bewley were based at hospitals with large numbers of drug dependent patients. Both were members of the ACMD, of which Connell was to become chairman in 1982, both held

⁶⁹ A. Thorley, (2002) *op. cit.*

⁷⁰ D. Turner [SCODA], Interview by Sarah Mars, (2002).

⁷¹ A. Thorley, (2002) *op. cit.*

⁷² *Ibid.*

⁷³ Anonymous, 'Journal Interview 27: Conversation with Philip Connell', *British Journal of Addiction*, 85, (1990) 13-23, p.13.

⁷⁴ T. Bewley, Interview by Sarah Mars, (2001).

⁷⁵ GMC, *Minutes of the General Medical Council and Committees for the Year 1979 with Reports of the Committees. etc.* CXVI (London: GMC, 1979).

⁷⁶ GMC, *Minutes of the General Medical Council and Committees for the Year 1991 with Reports of the Committees. etc.* CXXVIII (London: GMC, 1991).

⁷⁷ T. Bewley, 'Prescribing psychoactive drugs to addicts', *British Medical Journal*, 281 (1980) 497-498.

⁷⁸ T. Bewley, (2001) *op. cit.*

⁷⁹ A. Dally, *A Doctor's Story* (London: Macmillan, 1990) pp.141-144.

the post of specialist advisor to the Chief Medical Officer of drug dependence at various times and Dr Bewley was soon (in 1984) to become President of the Royal College of Psychiatrists.

T&R itself avoided taking a stand on maintenance prescribing because, it said, expert opinions differed and decisions depended on individual circumstances. This would seem to preclude the possibility of producing consensus guidelines on good prescribing practice, and yet this was exactly what *T&R* recommended. Paragraph 7.24 called for 'an authoritative statement of good practice, which should incorporate the need to make use of the support facilities we have mentioned... is required urgently.' The reference to 'support facilities' was another indication of the retention of an important role for the Clinics. This chapter of the report described how the Working Group had considered whether this could be drawn up by the ACMD but had concluded that 'since the matter is primarily one for the medical profession, the task should be undertaken by an ad hoc body of representatives of the profession.'

When David Turner had raised question of disparities in the Clinics' prescribing practices at the outset of the second Working Group's programme of work, Dr Bewley had commented at a meeting of the Working Group that there was a problem of appearing to interfere with doctors' clinical freedom by making recommendations about treatment and whether to prescribe or not.⁸⁰ Such guidelines drawn up by representatives of the medical profession would circumvent the problem as the profession would be regulating itself. One member recalled agreement on the Working Group, that 'the overall view around the table in *Treatment and Rehabilitation* was to see people come off drugs and that the idea of encouraging or in a sense, affirming their right to have long-term for life prescribing was not on,' but despite holding definite opinions the Group 'was shy of itself making a strong statement about treatment... it wasn't really the business of the Working Party'.⁸¹ This sensitivity over those outside the medical profession commenting on particular lines of treatment meant that production of the *Guidelines* was passed to an all medical working group.⁸²

The establishment of a medical working group also served another function. Those London psychiatrists who were against maintenance prescribing succeeded in moving discussion of the details of treatment content to an arena in which they were supreme. In the highly stratified world of medicine, Connell and Bewley, as the more experienced specialist hospital consultants held seniority; if an all-medical working group, as recommended by *T&R*, were set up to deal with this

⁸⁰ Home Office, TRWG Mins 23, Minutes of the 23rd Meeting of the Treatment and Rehabilitation Working Group, (27th November 1978), File D2/A242/12 Vol. G., DH Archive, Nelson, Lancashire.

⁸¹ A. Thorley, (2002) *op. cit.*

⁸² Senior Civil Servant, DHSS, Interview by Sarah Mars, (2001).

matter separately, their views would carry the greatest weight. The argument that doctors alone should determine prescribing policies may have been used by the London psychiatrists to ensure that the matter was left to a medical working group. In the event such a working group was to be chaired by Connell with Bewley as a member and their anti-maintenance approach was indeed victorious (see Chapter 4).

The decision by the Treatment and Rehabilitation Working Group to recommend setting guidelines seems to have been the result of a compromise. Some of the Working Group's psychiatrist members were pushing for statutory controls on prescribing to restrict drug treatment to the NHS and end private doctors' involvement. Opposing them was David Turner, a founder member and the director of the Standing Conference on Drug Abuse, representing voluntary drug services. Turner, like Bewley and Connell, was concerned about private doctors' prescribing but saw a danger in the Clinics holding a monopoly of uniform treatment.

The secretariat, and in particular the DHSS's medical advisor on drugs, Dr Dorothy Black, also supported a wider range of treatment choice than was being offered by the Clinics, and may have helped to broker this compromise.⁸³ The guidelines could offer a deterrent to private over-prescribers without recourse to the law. The idea may have been borrowed from the Association of Independent Doctors in Addiction (or AIDA, pronounced like the opera), a group of NHS and private doctors working outside the Clinics, led by high profile private doctor Ann Dally. AIDA had produced its own draft guidelines in 1982 on which Dorothy Black had provided comments, and these were circulated to the Treatment and Rehabilitation Working Group that year.^{84,85}

The extension of Home Office licensing to all opioids could also have effectively shut private doctors out of treating drug users, if licences had only been granted to doctors working in the Clinics, but some members of the Treatment and Rehabilitation Working Group did not object to the recommendation as they thought it unlikely to be implemented.⁸⁶

Among some of those responsible for the *Guidelines*, it has been claimed that the control of private doctors was a major, if not the primary motivation of those on the Treatment and Rehabilitation

⁸³ D. Turner [SCODA], (2002) *op. cit.*

⁸⁴ AIDA, 'Drug Addiction: Guidelines and Standards in Management', Pre-publication edition., February 1982, File PP/DAL./B/4/1/1/5, Wellcome Library.

⁸⁵ AIDA, TRWG(82)10, 'Drug Addiction: Guidelines and Standards in Management. Pre-publication edition, (February 1982), File DAC 7, DH Archive, Nelson, Lancashire.

⁸⁶ D. Turner [SCODA], (2002) *op. cit.*

Working Group who made the original recommendation for their production.⁸⁷ Supporting this was the strong justificatory attack on private doctors in *Treatment and Rehabilitation* and the use of the *Guidelines* in the actions against the best known private prescriber of the 1980s, Dr Ann Dally. In 1985, a year after their publication, Ann Dally was interviewed by inspectors from the Home Office Drugs Branch concerned about her prescribing, who compared her practice with that advised in the *Guidelines*.⁸⁸ The following year, the GMC's disciplinary case against Dr Dally quoted extensively from the *Guidelines*.⁸⁹ The fact that she had been a member of the Medical Working Group that had drafted them may have strengthened the case against her.

Producing the *Guidelines* put the spotlight on prescribing, apparently contradicting the central message of *Treatment and Rehabilitation* that medical treatment and substitute prescribing were only one component of the range of care needed by drug users. Out of a Working Group keen to emphasise the 'multi-disciplinary' approach to treatment and rehabilitation, and in which the medical members were free to comment on other members' areas of work, the medical members seemed to have found a way to protect their own contribution from the interference of other disciplines.

T&R contained some interesting contradictions regarding 'good practice' in treatment. It recommended the preparation of an 'authoritative statement' on good medical practice,⁹⁰ but it seemed to have reservations about the feasibility of this. At one point the text reconsidered what it saw as the second Brain Committee's dilemma 'as to how far it was right to offer drugs to addicts as an inducement to seek or maintain treatment', and answered accordingly 'We do not consider... that there can be any simple answer to the question since expert opinions differ and much must depend upon individual circumstances. Rather we prefer an alternative, more flexible approach responsive to the varying problems faced by drug users.'⁹¹ These apparently opposing views may have represented not just differences among the range of professionals, but divisions among the medical members.

Aside from these conflicts of opinion, the report also conceded the limited research base on which it could be based: 'It is not possible... on the basis of research undertaken so far to demonstrate

⁸⁷ A. Dally, Interview by Sarah Mars, (2002).

⁸⁸ D. Turner, (2002) *op. cit.*

⁸⁹ Senior Civil Servant, DHSS, (2001) *op. cit.*

⁹⁰ GMC Professional Conduct Committee, Day One, (9th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.1/10.

⁹¹ *Ibid.* pp. 1/10-1/13; 1/10-151; 1/56; 1/59.

⁹² ACMD, (1982) *op. cit.*, p.57.

⁹³ *Ibid.* p.33.

conclusively that one approach [to treatment and rehabilitation] is more effective than another'.⁹⁴ Then, rather surprisingly, the report declared that 'there has always been a broad consensus as to good and effective treatment of problem drug takers' but 'it has not always been widely known or widely applied'.⁹⁵ This varying range of views pointed to divisions within the Working Group over the content of treatment over which 'there was clearly going to be no agreement'.⁹⁶

Minutes from an ACMD meeting that approved *TeR* also suggested a split on the Council itself over the prospects for producing good practice guidelines. Members spoke both of the 'diametrically opposed views on treatment' among experts, making agreement on guidelines difficult, but also 'a pattern of good treatment practice which it was hoped would emerge in discussions'.⁹⁷ Like the Working Group, the Council itself seemed to have been divided over issues of maintenance and abstinence oriented treatments.⁹⁸

While the London psychiatrists had developed prescribing conformity among their ranks, if not consensus, general practitioners and private doctors had reached neither. As independent contractors to the NHS, and with so few of their number apparently interested in treating drug users, there was no equivalent attempt among the ranks of GPs to establish a clearly defined approach. Among the more patient-led private doctors who catered to needs or desires unmet by the NHS, there was greater sympathy for more liberal prescribing, and less concern about pressure from within the medical profession. Private prescribers did not require high status or position to continue to maintain a good income from the treatment of drug users. The main theoretical threat to their livelihood was from disciplinary action by the Home Office Drugs Inspectorate or the GMC which could stop such prescribing but this was relatively rare at this point. While the doctors outside the Clinics had tried to agree some criteria for good treatment by producing their own guidelines, ultimately they had 'agreed to differ' and the guidelines were never finalised (see Chapter 8).^{99,100}

⁹⁴ *Ibid.* p.22.

⁹⁵ *Ibid.* p.57.

⁹⁶ D. Turner [SCODA], (2003) *op. cit.*

⁹⁷ ACMD, ACMD (82) Second meeting minutes. (Meeting held on July 13 1982). File MDS/1/3 Vol 3, DH Archive, Nelson, Lancashire.

⁹⁸ A. Thorley, (2002) *op. cit.*

⁹⁹ AIDA, 'Drug Addiction: Guidelines and Standards in Management', Pre-publication edition, February 1982, File PP/DAL/B/4/1/1/5, Wellcome Library.

¹⁰⁰ AIDA, 'Minutes of first meeting of the Working Party', (24th November, 1981), File PP/DAL/B/4/1/1/4, Wellcome Library, London.

Attributing patients' move from the Clinics to outside doctors to the formers' reluctance to prescribe, Te&R considered these independent doctors an inadequate alternative as they did not have 'the resources to provide the full range of support services needed for the treatment and rehabilitation of drug misusers.'¹⁰¹ Such services were clearly only available in the hospital setting, supporting its case that patients should be treated there (the Working Group's preferred option), or that any doctor treating drug misusers outside hospital should do so in collaboration with hospital services.

It was Dr Bewley who suggested that prescribing outside the Clinics merited a separate chapter.¹⁰² Before this, the proposals for extending licensing to other drugs were already included. Indeed in discussions Dr Bewley had gone further still, suggesting that the extended licence should cover all drugs controlled under the Misuse of Drugs Act under classes A, B and C, not just opioids, something the London Clinics consultants had proposed back in 1968.¹⁰³ Dr Thorley thought that a wider extension to non-opioids was too radical to receive practical support¹⁰⁴ and it was never recommended. Spear has asserted that the proposed controls and their justifications in Chapter 7 'were little more than an elaboration of the consultants' views.'¹⁰⁵ However, other members have testified to agreement across the Working Group that private prescribing needed to be tackled.¹⁰⁶ Thorley explained,

*There was a real sort of keenness to try and tidy up the bad practice that existed in the private sector... So there wasn't a difference with Dr Bewley and the rest of the group I think on that one at all... And in fact, in a kind of way, I think it's quite reasonable to consider that one of the bedrock themes of the Treatment and Rehabilitation Group was to address this problem.*¹⁰⁷

Members from different professional backgrounds and with different agendas were united in their agreement over the problem but there seemed to have been different views on how it should be done. An early draft of Chapter Seven suggested that private doctors and GPs should only be granted licences to treat drug users if they worked with consultants in the Clinics. Although this idea was raised in the published chapter, it instead merely recommended close liaison with hospital

¹⁰¹ ACMD, (1982) *op. cit.*, p.33.

¹⁰² Home Office, TRWG (82) 24, (7th May 1982). File DAC 7, DH Archive, Nelson, Lancashire.

¹⁰³ J. L. Reed, "Meeting of Doctors Working in London Drug Dependency Treatment Centres, November 25th, 1969 at St Bartholomew's Hospital" [Minutes of meeting], Private Archive.

¹⁰⁴ A. Thorley, TRWG (82) 15, Memorandum to David Hardwick, (22nd March, 1982) File DAC 28, DH Archive, Nelson, Lancashire.

¹⁰⁵ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.276.

¹⁰⁶ D. Turner, (2002) *op. cit.*

¹⁰⁷ A. Thorley, (2002) *op. cit.*

services and access to expert second opinions. The call for reforms to the tribunals system were introduced in the new chapter.

The Conservatives' manifesto of 1979 pledged the Government to simplifying and decentralising the NHS. However, as Charles Webster has noted, in the health service and elsewhere, despite this commitment, the Government actually ended up introducing a much greater degree of central supervision over local activities.¹⁰⁸ The manoeuvres behind *TeR* illustrated this process, with centralising recommendations emanating from the Working Group, opposed by civil servants in the belief that they were 'upholding Ministers' policies' of decentralization,¹⁰⁹ who were in turn overruled by ministers wanting to control matters from the centre.

The report's first recommendation was for an expansion of the arrangements for central government to give advice and support to local agencies. The draft government response prepared by a DHSS official rejected this as it would 'conflict with Government policy on non-interference with local decisions on the allocation of local resources'.¹¹⁰ Kenneth Clarke, then Minister for Health, was 'not very impressed' with this draft response and, in a memo to Norman Fowler, then Secretary of State at the DHSS, stated that 'Leaving the provision of service to "local decision-makers" will not make much progress unless we give them a steer'.¹¹¹ Furthermore, the government was also already committed to spending six million centrally allocated pounds on developing drug services on the Working Group's recommendation.

This first recommendation was in fact a retreat from the Working Group's original desire for 'a central QUANGO to provide service or lay down strategies'. Again the DHSS civil servants dissuaded the Working Group – this time successfully – but according to one of the officials 'they still hanker[ed] after a central monitoring/advisory team on HAS lines'.¹¹² This referred to the Health Advisory Service, a body that monitored the NHS funded by the DHSS.

¹⁰⁸ C. Webster, *The National Health Service. A Political History*. (Oxford University Press, Oxford: 1998) pp.140-219.

¹⁰⁹ A. M. Blythe, Memo from to J M Rogers, (19th February 1982), File 16/DAC 28 Vol 2, DH Archive, Nelson, Lancashire.

¹¹⁰ ACMD: Report on Treatment and Rehabilitation. Draft Submission, (November 1983) From File DAC 14 Volume 4, DH Archive, Nelson, Lancashire.

¹¹¹ K. Clarke, Memo to Secretary of State, (31st October 1983), File DAC 14 Volume 4, DH Archive, Nelson, Lancashire.

¹¹² A. M. Blythe, Memo from to J M Rogers, (19th February 1982), File 16/DAC 28 Vol 2, DH Archive, Nelson, Lancashire.

When submitted to the Advisory Council itself, the new chapter on 'Prescribing Safeguards' elicited opposing responses. A minute of the July 1982 meeting showed that the ACMD did not wish to change it but some members felt that the report was too critical of private prescribers: although some private practitioners had misused their powers to prescribe, so too had NHS practitioners. 'Others pointed out that when patients were paying for prescriptions for drugs of addiction... there was more potential for abuse.'¹¹³

Use of Evidence

The *Treatment and Rehabilitation* report made very little reference to published research evidence. Only the three pages concerning 'The effectiveness of treatment and rehabilitation' referred to a handful of research studies. Statistics from the Home Office on the number of patients in treatment, drug offenders and drug seizures were used in the report, and provided as an appendix, but most of the evidence used by the Treatment and Rehabilitation Working Group was of a more informal type, derived from the experiences of its members and their visits around the country. These trips provided the opportunity for discussions with a wide range of workers in contact with drug users and with patients, ex-addicts and other concerned individuals, who were listed by their job title or role in an appendix. The T&R Working Group also took oral evidence at meetings. T&R's cause for concern about doctors working away from hospital-based services was based on discussions with the Home Office Drugs Branch Inspectorate, doctors from the DHSS, doctors working with drug users and views expressed in medical journals and elsewhere.¹¹⁴

The lack of cited research evidence seemed in part to be a result of its limited availability at that time, the central point made in the report's chapter on research, and was confirmed elsewhere.¹¹⁵ However, other reports by the ACMD published during the 1980s on topics for which there was much more research evidence, such as HIV/AIDS,¹¹⁶ also lacked citations, relying again on submissions to the committee from organisations and individuals. The fact that the ACMD published reports during the 1980s without perceiving a need to support its statements through reference to published research implied a reliance on its authority as a body. 'Expertise' resided in its committee members' experience and assumed impartiality with an expectation that their conclusions could be trusted and that the information from which they were drawn did require independent scrutiny. This approach was not uncommon in medicine before the advent of

¹¹³ ACMD (82) 2nd meeting minutes. (Meeting held on July 13 1982). File MDS/1/3 Vol 3, DH Archive, Nelson, Lancashire.

¹¹⁴ ACMD, *Treatment and Rehabilitation* DHSS, (London: HMSO, 1982).

¹¹⁵ A. Thorley, 'Longitudinal Studies of Drug Dependence' in G. Edwards and C. Busch (eds.) *Drug Problems in Britain: A Review of Ten Years* (London, Academic Press, 1981), 117-169.

¹¹⁶ eg. ACMD, *AIDS and Drug Misuse Part 2* (London: HMSO, 1989).

'evidence-based medicine' but in such a politicised field the assumption of an objective, neutral expertise, whether truly possible in any circumstances, could be particularly ill-founded.

Reception of Treatment and Rehabilitation

Aside from what it said, *T&R* was a significant report because government implemented so many of its recommendations. The reason for ministers' responsiveness and willingness to spend money on drug services has been attributed to their keen interest in drug misuse at the time, referred to both between DHSS civil servants at the time and subsequently,^{117,118} which in turn reflected the dramatic increase in Britain's drug use, particularly heroin.

The government was also keen to gain the support of the medical profession for the report's proposals and called a conference of medical representatives in January 1983 to achieve this. Norman Fowler, the Secretary of State at the DHSS, gave the keynote address, a departure from the normal protocol under which a more junior minister or senior official would have addressed the conference,¹¹⁹ again reflecting the priority given to this area. His interest in the topic dated back to his time as a journalist before entering politics.

Overall the minister seems to have received a positive response from the medical representatives who showed no greater sympathy for private prescribers than the Treatment and Rehabilitation Working Group. A note of the meeting showed some disquiet about 'the principle of private prescribing' in view of the charging of fees, but these comments were unattributed.¹²⁰ There appeared to have been dissent as to whether GPs should treat drug misuse but agreement that if they were to be, training and additional support would be required.¹²¹ The BMA's General Medical Services Committee, representing the majority of GPs, supported the recommendations for good practice guidelines and for the extension of licensing initially to dipipanone and later other opioids,¹²² as did the majority of medical representatives.

¹¹⁷ Senior Civil Servant, DHSS, Interview by Sarah Mars (2001).

¹¹⁸ A. M. Blythe, Memo to M. Moodie. 'Services for Drug Misusers. ACMD', (5th February 1982), File DAC 7, DH Archive, Nelson, Lancashire.

¹¹⁹ Senior Civil Servant, DHSS, (2001) *op. cit.*

¹²⁰ Anonymous, 'Note of the One-day medical conference convened at the DHSS to discuss the medical response to the ACMD report on Treatment and Rehabilitation on 28th January 1983'. File DAC 28, DH Archive, Nelson, Lancashire.

¹²¹ *Ibid.*

¹²² J. Webb, Letter to E. Shore, Deputy Chief Medical Officer, DHSS. (12th October, 1984) File DAC 28, DH Archive, Nelson, Lancashire.

The requirements for doctors to obtain licences proposed at the January 1983 medical conference were strict: those who wished to be able to prescribe methadone and other opioids by Home Office licence should have additional training, multi-disciplinary support, and membership of the Royal College of General Practitioners or the British Medical Association.¹²³ These obstacles to practice may have reflected the general lack of enthusiasm among GPs for treating drug users. Another suggestion was that the number of drug dependent patients should be limited to 3 or 4 on any GP's list – this would have effectively ended private prescribing on any significant scale.

A wider range of views was recorded on the utility of or necessity for good practice guidelines and the Department agreed to invite further small groups to consider both the question of licensing and the preparation of guidelines in the light of responses to a wider consultation exercise.¹²⁴ A civil servant's draft of Norman Fowler's letter to the Home Secretary gave a rather more triumphant tone to Fowler's achievements at this meeting where he 'secured a favourable climate' for the establishment of the good practice guidelines and licensing working group.¹²⁵ In the actual letter Fowler sent, mention of the 'favourable climate' had been removed.¹²⁶

Conclusion

Treatment and Rehabilitation heralded many changes to the freedoms and responsibilities of doctors working outside the Clinics and the first major regulatory interventions against private doctors since the Brain Committee's changes of the late 1960s. While attacking private doctors, *T&R* also gave approval to the involvement of the generalist in the treatment of drug users, reversing over a decade's policy of exclusion. Such expansion and concerns over existing non-Clinic prescribing were used to justify the retention of power for the hospital consultants and central government through the development of new and existing control mechanisms. These controls were in fact primarily designed for existing private prescribers rather than anticipated GP involvement.

That the report's recommendations were implemented almost wholesale can be attributed to widely publicised changes in the landscape of drug taking in Britain since the late 1970s and the subsequent political will to address these publicly. Some of these wide reaching changes might never have been suggested or given such prominence had it not been for the determination of a few individuals deeply concerned about the role of private prescribers and perceived

¹²³ Anonymous, 'Note conference on 28th January 1983', *op. cit.*

¹²⁴ *Ibid.*

¹²⁵ Anonymous, Draft reply to Home Secretary from Norman Fowler (undated) File DAC 14 Volume 4, DH Archive, Nelson, Lancashire.

¹²⁶ N. Fowler, Letter to L. Britton (30th November 1983), File DAC 14, DH Archive, Nelson, Lancashire.

encroachments on their dominant position. Although expanding, the still small size of the drugs policy community in the late 1970s and early 1980s allowed some ambitious individuals to gain great influence across a number of settings. Philip Connell and Thomas Bewley's authority within the London psychiatric drugs field and their presence on this and subsequent working groups played a pivotal role in seeking to control private prescribing. And although opposed to the Clinic monopoly over controlled drug prescribing sought by the consultants, concerns about private prescribing struck a chord with the voluntary sector representation as well.

While the second Brain Committee had been entirely medical, in the day of the Treatment and Rehabilitation Working Group medicine was having to make room for other disciplines and occupational groups. Non-medical members wielded considerable influence, with T&R's radical agenda set by David Turner at the outset of the second Working Group. Yet it still successfully defended its territory from infringements, and managed to keep the most controversial treatment issue – namely prescribing – within its professional borders. The story of what happened within those borders is the subject of the next chapter.

Chapter 4

Major Regulatory Interventions I:

The Guidelines of Good Clinical Practice in the Treatment of Drug Misuse (1984)

Introduction

In 1984, amid a steep increase in the number of drug users seeking treatment, the Department of Health and Social Security (DHSS) published the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse*,¹ one of the first official clinical guidelines in British medicine. The proliferation of clinical guidelines and protocols which followed, particularly after the NHS market reforms of 1991, has been interpreted as the increasing of state control over the medical profession and a weakening of medical autonomy.² However, this chapter argues that these first clinical guidelines represented the use of regulation by an alliance of one part of the medical profession and an arm of the state to control the practice of a second group of doctors. The *Guidelines* were used to secure the ascendancy of one particular treatment model and impose this on all doctors, while citing no supporting published research evidence. The experience of an expert committee was deemed by government and many of those involved to be sufficient for determining 'good practice'.

Background and Context

In 1982, the ACMD had published *Treatment and Rehabilitation*. As discussed in the previous chapter, its recommendations were to change the direction of drug treatment policy in England. At that point, doctors working outside the Clinics were still able to prescribe methadone, a synthetic opiate used to replace heroin, dexamphetamine (a stimulant of the amphetamine family) and other substitute drugs, and their prescribing was receiving unwelcome attention, particularly from senior consultant psychiatrists in the London Clinics. Chief among those irritated by the private prescribers were Dr Thomas Bewley and Dr Philip Connell who had led the move from maintenance heroin prescribing to short term methadone detoxification, and from injectable to oral formulations across the London Clinics.

¹ Medical Working Group on Drug Dependence, *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* (London: DHSS, 1984).

² S. Harrison and W.I.U. Ahmad, 'Medical autonomy and the UK state 1975-2025', *Sociology*, 34 (2000), 129-146.

In the 1970s and early 80s little research had been carried out to evaluate these different approaches to prescribing,¹ and what existed was often misrepresented. Richard Hartnoll and Martin Mitcheson's randomised trial of injectable heroin and oral methadone was frequently cited to justify the prescribing changes in the Clinics and had been key in achieving the move from maintenance prescribing of heroin to limited stabilisation on methadone followed by short term detoxification, often with obligatory therapy sessions.²

In the early 1970s Richard Hartnoll and Martin Mitcheson randomly allocated 96 opiate dependent patients at a North London Clinic to either injectable heroin or oral methadone maintenance treatment and then followed up a year later.³ The research was carried out between 1972 and 1976 but was unpublished until 1980. However, in the 1970s its findings were frequently cited to justify the prescribing changes in the Clinics.⁴ In a published paper the study's authors were equivocal about its findings, stressing they showed no one treatment to be superior. Although their results showed different positive and negative points for both the heroin and the methadone prescription groups, 'the differences between the two groups, although often statistically significant are not startling. Which ever treatment is given, there are obvious casualties that may reflect the pre-existing chaos of the patients as much as the treatment offered.'⁵ The authors concluded that the findings 'contribute to a more informed discussion' of the issues around heroin prescription 'rather than provide an unequivocal answer.'⁶ Yet in spite of these cautious words, the research was used to justify a switch away from heroin prescribing and towards oral methadone. Martin Mitcheson, co-author of the study, stopped prescribing injectable drugs entirely to new patients at his Clinic after the research was completed in the mid-1970s.⁷

Senior Clinic consultant Dr Thomas Bewley described how, because the evidence showed neither drug to be superior, 'I felt it was open to the prescriber to choose so I moved over to methadone and phased out heroin',⁸ trying to encourage other doctors to follow suit. One of the opponents of the Clinics' switch to methadone complained that 'while critics of what the [Clinics] were doing

¹ A. Thorley, 'Longitudinal studies of drug dependence' in G. Edwards and C. Busch (eds.) *Drug Problems in Britain: A Review of Ten Years* (London, Academic Press, 1981), 117-169.

² M. Mitcheson, 'Drug clinics in the 1970s' in J. Strang and M. Gossop (eds.), *Heroin Addiction and Drug Policy: The British System* (Oxford, New York and Tokyo: Oxford University Press, 1994) pp.179-191.

³ R. Hartnoll, M. C. Mitcheson, A. Battersby, G. Brown, M. Ellis, P. Fleming, N. Hedley, 'Evaluation of heroin maintenance in controlled trial', *Archives of General Psychiatry*, 37 (1980), 877-884.

⁴ G. V. Stimson and E. Oppenheimer, *Heroin Addiction: Treatment and Control in Britain* (London: Tavistock Publications, 1982) pp.215-219.

⁵ R. Hartnoll, M. C. Mitcheson, A. Battersby *et al.*, p.883.

⁶ *Ibid.* p.883.

⁷ M. Sharpe, Interview by Sarah Mars, (2001).

⁸ T. Bewley, Interview by Sarah Mars, (2001).

were required to produce data to support their criticisms', one of its proponents had freely admitted that there was 'no scientific basis' for this major change.¹¹ By the time the *Guidelines* were being drafted in 1984, oral methadone detoxification was the only option offered to new patients seeking help from the Clinics.

The London Clinics' unified approach was facilitated by a regular meeting of their consultant psychiatrists, from 1968,¹² in order to share information and standardise practice. This was held first at the DHSS and from 1977 at the Home Office.¹³ Martin Mitcheson, a consultant at University College Hospital DDU, described these meetings as 'typically English, discreet peer group pressure tending to moderate the prescribing of heroin' in order to prevent drugs being traded illegally.¹⁴

One DDU consultant psychiatrist who continued to disagree with the anti-maintenance approach at the London consultants groups claimed to have been pressurised to conform when he persisted with the practice.¹⁵ Another complained that these conformist pressures produced farcical double standards: doctors who continued to prescribe injectable heroin were criticised but licensed colleagues in other Clinics would phone to ask them to prescribe heroin to a patient because, although licensed, they did not feel able to do so themselves.¹⁶ (The London Consultants Group is considered in detail in Chapter 8.)

Over this period the relationship between the prescribers and the black market also changed. In their early days, the Clinics, as monopoly suppliers of drugs, had pursued a practice known as 'competitive prescribing' as a deterrent against the development of the black market. They therefore took a dual role of treating drug users and controlling the wider drug supply, aiming to treat individual patients and protect wider public health through controlling the availability of drugs.¹⁷ At this point, prescribers could influence the supply of drugs considerably because there was little supply of trafficked drugs available, but this changed in the late 1970s and by the early 1980s the substantial supplies of smuggled heroin entering Britain provided a burgeoning black market.

¹¹ H. B. Spear (and ed. J. Mott), *Heroin Addiction Care and Control: the 'British System' 1916-1984* (London: Drugscope, 2002) pp.245-246.

¹² DHSS, 'Drug dependence: clinical conference', [Minutes of meeting] (28th November 1968), Private archive.

¹³ H. B. Spear (and ed. J. Mott) (2002), *op. cit.*, p.243.

¹⁴ M. Mitcheson, (1994) *op. cit.*, pp.178-179.

¹⁵ K. Sathananthan, Interview by Sarah Mars, (2001).

¹⁶ J. H. Willis, 'Unacceptable face of private practice: prescription of controlled drugs to addicts' [letter], *British Medical Journal*, 287 (1983), 500.

¹⁷ G. V. Stimson and E. Oppenheimer, (1982) *op. cit.*, pp.54-56.

Insufficient treatment places in the Clinics and the spread of heroin use to parts of the country without specialist provision were the context against which drug users were increasingly seeking treatment from NHS or private general practice.¹⁸ The move away from the Clinics may have resulted not just from their long waiting lists but also because of their changing prescribing policies,¹⁹ particularly in London. Clinic psychiatrists expressed disquiet at these changes, particularly regarding private doctors prescribing outside the Clinic system on a fee-paying basis.

In 1980 the first open attack on private prescribing had appeared in the *British Medical Journal*, in which its author commented, 'There are strong economic pressures on addicts to try to obtain controlled drugs on prescription and then to sell some of them; and there are subtle pressures on a doctor who considers prescribing privately to convince him that he will be treating patients rather than selling drugs... The medical profession should consider whether there is any place for private treatment of addicts where a fee is contingent of a prescription.'²⁰

A vehement debate developed around the differences in prescribing methods of these groups of doctors, emerging in the medical press²¹ and official reports,²² sometimes spilling into disciplinary cases at the General Medical Council (see Chapter 5).²³ Private prescribers were accused of selling drug prescriptions for profit rather than treating patients,²⁴ while private doctors accused the Clinics of failing to meet addicts' needs. Among their alleged shortcomings were the prescription of drugs only after delays or in formulations unacceptable to their patients, both of which, it was claimed, led drug users to buy more dangerous black market drugs to prevent withdrawal symptoms.²⁵ One of the most vigorous defenders of private prescribing, Dr Ann Dally, was to become a member of the committee responsible for the *Guidelines*, and her prescribing was also subject to disciplinary hearings before the GMC.

The peer pressure exercised successfully by the London psychiatrists continued after heroin prescribing had diminished, successfully effecting the move towards prescribing injectable and then oral methadone in the Clinics. It had not, however, succeeded in imposing conformity on the

¹⁸ See ACMD, *Treatment and Rehabilitation*, DHSS (London: HMSO, 1982) pp.26-27.

¹⁹ J. Strang, 'Personal view', *British Medical Journal*, 283 (1981), 376.

²⁰ T. H. Bewley, 'Prescribing Psychoactive Drugs to Addicts', *British Medical Journal*, 281 (1980), 497-498, p.497.

²¹ eg. T. Bewley and A. H. Ghodse, 'Unacceptable face of private practice: prescription of controlled drugs to addicts', *British Medical Journal*, 286 (1983), 1876-1877.

²² ACMD, (1982) *op. cit.*, pp.51-62.

²³ See A. Dally, *A Doctor's Story* (London: Macmillan, 1990).

²⁴ T. H. Bewley, (1980) *op. cit.*, p.497.

²⁵ eg. A. Dally, 'Drug clinics today' [letter], *The Lancet*, 8328 (1983), 826.

practice of private prescribers or general practitioners prescribing outside the Clinics, both of whom greatly valued their independence from their peers.

Conservative politicians, who might be seen as champions of private treatment for drug users, did not involve themselves in this particular debate. Although the new Conservative government of 1979 had greatly facilitated the supply of consultant labour to the private sector,²⁶ private prescribing for the treatment of addiction by NHS Clinic psychiatrists was rare and not well respected. The 1979 Conservative manifesto had proposed an end to the 'vendetta' against private practice and its 1983 successor encouraged a positive role for private medicine.²⁷ However, this did not include drug treatment which was dealt with as a 'drugs' issue rather than a 'private medicine' issue, and as such was not treated as a party political concern.

Home Office Drugs Inspectorate

Unlike other areas of prescribing dealt with by the GMC as part of the medical profession's self-regulating remit, the prescription of controlled drugs such as heroin, cocaine and methadone also came under the scrutiny of the Home Office. These powers had a precedent in the unsuccessful Inebriates Acts of the late nineteenth century and they developed during and after the First World War. Amendments to the Defence of the Realm Act passed in 1916 empowered the Home Secretary to withdraw from a doctor the power to prescribe cocaine if he was convicted of an offence under the Act and controls on opiates followed. Home Office officials were detailed to monitor compliance and in 1917 this authority was extended to senior police officers.²⁸ Building on these developments, the Dangerous Drugs Act, 1920, developed two different systems of monitoring: the Home Office's own Drugs Inspectorate and the police's chemist inspecting officers concerned with criminal offences. 'Irresponsible prescribing' by doctors concerned the Home Office, rather than the police, but was not defined by law and up until publication of the *Guidelines*, the Home Office had no official measure against which to gauge it.

Much of the Home Office Inspectorate's regulatory work was carried out on an official but informal basis, with inspectors visiting doctors and advising them to modify their practice.²⁹ On rare occasions, doctors were summoned to a Home Office Tribunal that had the power to remove their right to prescribe controlled drugs. H.B. 'Bing' Spear, Chief Drugs Inspector from 1977 to 1986, and active in the Inspectorate since 1952, took a personal interest in the prescribing habits of

²⁶ W. Laing, *Going Private. Independent Health Care in London* (London: King's Fund, 1992).

²⁷ C. Webster, *The National Health Service. A Political History* (Oxford: Oxford University Press, 1998) p.146.

²⁸ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.37

²⁹ *Ibid.* p.260.

doctors and in the wellbeing of their patients, and possessed an intimate knowledge of the drugs 'scene'. In this role he became not merely an implementer of others' policy, but a major influence in his own right. Moving, as he did, among the doctors, civil servants, committees and drug users on the streets, he was recognised by all sides of the prescribing debate as one of the most knowledgeable and trustworthy sources of information and guidance.^{30,31,32} Although a strong supporter of doctors' freedom to prescribe on a maintenance basis and an opponent of the changes brought in by the London Clinic psychiatrists, he also believed in the need to regulate doctors' prescribing.³³

Until 1986 Spear attended most of the London Clinic psychiatrists' meetings,³⁴ where he was able to provide information to the consultants and in his regulatory capacity could follow up reports of 'irresponsible prescribing' among private prescribers and other doctors.³⁵ The Home Office Drugs Tribunals, used to discipline doctors considered to be prescribing irresponsibly, were only directed against doctors working outside the Clinics.³⁶ The Clinics were therefore free to prescribe within the standards they set for themselves, and the picture was one of self-regulation rather than regulation by the state.

Membership and intentions of the Medical Working Group

At the Treatment and Rehabilitation Working Group, the medical profession had successfully preserved prescribing policy for themselves; encouraged and facilitated by the DHSS, and its medical civil servants, the *Guidelines*' membership reflected this. Most of the all-Medical Working Group's members had been nominated by medical bodies on the suggestion of the DHSS: the General Medical Council, British Medical Association, the Royal Colleges of Psychiatrists and General Practitioners, the Joint Consultants' Committee and the Association of Independent Doctors in Addiction (AIDA).

The presence of AIDA, whose president was Dr Ann Dally, the most outspoken private prescriber of the 1980s, was a deliberate political move by the chairman and secretariat to create at least the appearance of a consensus statement.^{37,38} Views have varied as to whether this was a genuine

³⁰ T. Bewley, Interview by Sarah Mars, (2001).

³¹ A. Dally, (1990) *op. cit.*, pp.71-275.

³² D. Turner [SCODA], Interview by Sarah Mars, (2002).

³³ eg. H. B. Spear (and ed. J. Mott) (2002), *op. cit.*, pp.62-63.

³⁴ eg. *Ibid.* p.62.

³⁵ T. Bewley, (2001) *op. cit.*

³⁶ Home Office, Personal communication, (2002).

³⁷ Senior Civil Servant, DHSS, (2001) *op. cit.*

³⁸ H. D. Beckett, Interview by Sarah Mars, (2001).

intention to take on the views of private doctors or in fact an attempt 'to smother the enemy... by creating something they appear to agree with'.³⁹ Professor Neil Kessel, in his role as the Chief Medical Officer's advisor on alcohol, was appointed to the Working Group and a minority were invited for their particular expertise: Dr Arthur Banks had written on treating drug users in general practice,^{40,41} and Dr Elizabeth Tylden was an authority on drug use in pregnancy.⁴² There was therefore a mix of representation from medical bodies and expertise in the drugs field, across NHS and private medicine.

The original aims of the psychiatrist members of the Treatment and Rehabilitation Working Group and the chairman of the Medical Working Group, Dr Philip Connell, in producing the good practice *Guidelines* can be summarised as controlling doctors working outside the Clinics, particularly those in private practice,^{43,44} retaining dominance for drug dependence psychiatrists and their preferred treatment model, and preventing diversion of prescribed drugs onto the black market. Indeed the first papers circulated to Medical Working Group members were an article criticising private prescribing and related correspondence in the *British Medical Journal* and the *Lancet*.^{45,46}

Dr Thomas Bewley's motives were similar to those of Dr Connell and could be described as stopping maintenance prescribing and promoting the model of treatment dominant among London psychiatrists. Dr Bewley, at this time, had been won over to methadone from heroin prescribing after meeting Vincent Dole, a pioneer of methadone substitution therapy, during a visit to the US in 1967.^{47,48} He also hoped to bring private prescribing to an end.^{49,50}

Dr Arthur Banks, a GP in Chelmsford, Essex, with considerable experience of treating drug users, wished to encourage other GPs to get involved. There was little published guidance available to GPs at that time and he hoped that the *Guidelines* would give them greater confidence and show their obligations in treating drug users. He wanted 'something official that was a considered

³⁹ D. Turner, (2002) *op. cit.*

⁴⁰ eg. T. Waller and A. Banks, 'Drug abuse pull out supplement', *GP*, (25th March 1983), 27-45.

⁴¹ eg. A. Banks and T. A. N. Waller, *Drug Addiction and Polydrug Use: The Role of the General Practitioner* (London: ISDD, 1983).

⁴² eg. E. Tylden, 'Care of the pregnant drug addict', *MJMS*, 1st June (1983), 1-4.

⁴³ A. Thorley, Interview by Sarah Mars, (2002).

⁴⁴ Senior Civil Servant, DHSS, (2001) *op. cit.*

⁴⁵ T. Bewley and A. H. Ghodse, (1983) *op. cit.*, pp.1876-1877.

⁴⁶ A. Dally, (1983) *op. cit.*, p.826.

⁴⁷ Anonymous, 'Journal Interview 36: Conversation with Thomas Bewley', *Addiction*, 90 (1995), 883-892.

⁴⁸ T. Bewley, 'Drug dependence in the USA', *Bulletin on Narcotics*, XXI, 2 (1969), 13-29.

⁴⁹ See T. H. Bewley, (1980) *op. cit.*, p.497.

⁵⁰ See T. Bewley and A. H. Ghodse, (1983) *op. cit.*, pp.1876-1877.

document summarising the best ideas on treatment of drug addicts and something that would be available to all GPs.⁵¹ He did not have specific concerns about the potential for the *Guidelines* to enforce a particular model but strongly opposed the extension of licensing to all opioids, seeing it as likely to destroy any emergent interest in treating drug users from general practice.⁵² He also wanted to show GPs that there was government backing for their involvement independent from addiction psychiatrists.

Private doctor Ann Dally also opposed the extension of licensing, and wished to promote her views on treatment, including the need for long term prescribing. Like virtually all doctors practising outside the Clinics, she did not have a licence to prescribe heroin or cocaine. A fellow member recalled that she 'fought her corner with great vigour'.⁵³ Had the licensing system been extended to cover all opioid drugs, she might have been denied the right to continue prescribing and so would have had to cease her practice. She saw herself as one of a group of 'dissidents' which included Dr H. Dale Beckett whom she had invited onto the Medical Working Group from AIDA, and sometimes Arthur Banks, opposing the psychiatric 'establishment' on the committee.^{54,55} Psychiatrist Dale Beckett, at this stage retired from his NHS consultant post in charge of a Clinic at Cane Hill Hospital, Surrey, and working in private practice, held unorthodox views on the rights of drug users to maintenance supplies, believing that heroin, a 'gentle drug', should be made available to addicts and he supported Ann Dally on treatment and licensing issues.^{56,57}

Among the representatives of the medical bodies without specific drugs expertise, the BMA's Dr J A Riddell, a Glasgow GP, strongly opposed GP involvement in treating drug users.⁵⁸ 'He just felt they'd be overwhelmed; there'd be more problems because they wouldn't cope',⁵⁹ and on most issues the other non-expert representatives tended to side with the psychiatrists, including on the matter of licensing.^{60,61}

⁵¹ A. Banks, Interview by Sarah Mars, (2001).

⁵² A. Banks, Letter to N. Fowler, MP, (1983), Ref 40117, DrugScope Library, London

⁵³ A. Banks, (2001) *op. cit.*

⁵⁴ A. Dally, *A Doctor's Story* (London: Macmillan, 1990) pp.127-132.

⁵⁵ A. Thorley, (2002) *op. cit.*

⁵⁶ H. D. Beckett, 'Heroin, the gentle drug', *New Society*, 49, 877 (1979), 181-182.

⁵⁷ H. D. Beckett, Interview by Sarah Mars, (2001).

⁵⁸ A. Banks, (2001) *op. cit.*

⁵⁹ Senior Civil Servant, DHSS, (2001) *op. cit.*

⁶⁰ A. Banks, (2001) *op. cit.*

⁶¹ A. Dally, (1990) *op. cit.*, pp.127-132.

In the Medical Working Group, the push for additional restrictions on prescribing through further Home Office licensing, which would have considerably reduced doctors' clinical autonomy, came from the psychiatrist members appointed by the secretariat. It was supported by many of the elected doctors and opposed by medical civil servants at the DHSS and administrative civil servants at the Home Office.^{62,63} Although it was unknown how exactly such a licensing system would have operated, it was unlikely that it would have had an impact on the prescribing of the Clinic psychiatrists who already held Home Office licences for heroin and cocaine prescribing. The group recommended by a vote of eleven in favour, one abstention and three opposed, that licensing restrictions should be extended to all opioids except oral methadone,⁶⁴ but it was later over-ruled by ministers as unnecessary and possibly likely to deter GPs from treating drug users.^{65,66}

The Role of the Secretariat

The secretariat to the Medical Working Group was provided by Dr Dorothy Black, senior medical officer dealing with drugs policy at the DHSS, and Mr R Wittenberg, a career civil servant. Dr Black, who came to the Department in 1981 from her post as consultant psychiatrist working with drug users in Sheffield, was particularly influential in drug service policy of the early 1980s. Despite sharing a medical specialty, she did not automatically side with the dominant London addiction psychiatrists and was encouraging of non-statutory and non-medical involvement in drug treatment services.⁶⁷ Her experience of patterns of drug use outside of London was important in countering the London-centric policy making of the period.⁶⁸ While attending the Treatment and Rehabilitation Working Group, she is thought to have been responsible for suggesting the *Guidelines* recommendation as a compromise between the London consultants' call for legal regulatory changes and those opposing them. One member of the Treatment and Rehabilitation Working Group commented,

Dorothy Black was important... in avoiding formal regulation in favour of guidelines... Partly I think that regulation was a rather impractical process but secondly I think that Dorothy was more conscious of the need for a greater range of treatment options rather than a very standardised system [of the Clinics].⁶⁹

⁶² Senior Civil Servant, DHSS, (2001) *op. cit.*

⁶³ Home Office, MWG (84) 33, 'Power to restrict licences to prescribe under Misuse of Drugs Act 1971', (1984) Private archive.

⁶⁴ D. Black, 'Medical Working Group on Drug Dependence', (1985), File 16/DAC 28/2, DH Archive, Nelson, Lancashire.

⁶⁵ D. Mellor, Letter to R. Whitney, (10th December 1985), File 16/DAC 28/2, DH Archive, Nelson, Lancashire.

⁶⁶ J. Patten, Letter to D. Mellor, (15th May 1985), File 16/DAC 28/2, DH Archive, Nelson, Lancashire.

⁶⁷ A. Thorley, (2002) *op. cit.*

⁶⁸ Senior Civil Servant, DHSS, (2001) *op. cit.*

⁶⁹ D. Turner, (2002) *op. cit.*

Her wide scope to initiate policy in the DHSS of the early '80s seems to have been facilitated by both the lack of interest in drug treatment policies among the administrative civil servants (ie. those who were employed as career bureaucrats rather than hired for their particular expertise in a subject) and the enthusiastic support of Norman Fowler, then Secretary of State, whose interest in drug issues predated his political career.⁷⁰ According to a contemporary source in the Department, 'there was nobody else in the Department who knew anything at all about drugs... from the point of view of the administrative civil servants it was almost seen as being sent to Mongolia.'⁷¹ Dr Black was closely involved in the selection process for membership of the Medical Working Group and carried out most of the *Guidelines* drafting work as Mr Wittenberg was unwell for much of the project.⁷²

An important feature of the DHSS was the inclusion of medical civil servants on its staff directly answerable until 1995,⁷³ to the Chief Medical Officer. These medical civil servants acted as 'experts' and tended not to become fully assimilated into the bureaucracy. Compared to the administrative staff they had considerable independence⁷⁴ to work as 'professionals' and played a significant part in initiating policy, which was then carried out by the administrative staff.⁷⁵ For instance, as DHSS 'observers' on ACMD Working Groups, they were encouraged to speak as experienced clinicians rather than administrators,⁷⁶ and many working in drug and alcohol policy returned to clinical work after periods at the Department during the 1980s and '90s. In addition to the secretariat who drafted the document, observers from both the DHSS and Home Office attended the Medical Working Group's meetings, reflecting the Home Office's regulatory interest.

Regulation by the State

The *Guidelines* quoted *Treatment and Rehabilitation's* hope that 'these guidelines would help to identify those cases where prescribing practices might be regarded as irresponsible.'⁷⁷ The *Guidelines* were therefore valuable to the Home Office Drugs Inspectorate in their role of advising doctors and bringing Tribunal proceedings against them. In this they were helping the state use bureaucratic rules to control otherwise self-regulating professionals.

⁷⁰ Senior Civil Servant, DHSS, (2001) *op. cit.*

⁷¹ *Ibid.*

⁷² *Ibid.*

⁷³ A. Thorley, (2002) *op. cit.*

⁷⁴ Senior Civil Servant, DHSS, (2001) *op. cit.*

⁷⁵ A. Thorley, (2002) *op. cit.*

⁷⁶ Senior Civil Servant, DHSS, (2001) *op. cit.*

⁷⁷ ACMD, *Treatment and Rehabilitation*, DHSS (London: HMSO, 1982) p.59.

⁷⁸ Medical Working Group on Drug Dependence, (1984) *op. cit.*, p.3.

As a DHSS civil servant commented, 'The Inspectorate, if you like, had their own internal view [on prescribing] and there'd never been any guidelines before...it would reinforce what the Inspectorate said as they trundled round all the doctors.'

Not only were the *Guidelines* official, but they gave an appearance of medical self-regulation, rather than regulation by the state. For the Inspectorate it would 'give them another piece of support when they were advising doctors, that...to a doctor it might be more effective in influencing their practice to say "This is from a working party of doctors", rather than saying as a Home Office Inspector, "Do you think your prescribing levels are too high?"'⁷⁹

The Home Office did not, however, seek the extension of licensing, which could have given it greater powers over prescribing drugs. This may have been because the most influential civil servant in this field, Bing Spear, then Chief Home Office Drugs Inspector, was not sympathetic to the leading psychiatrists advocating the licensing extension, such as Philip Connell, who he described as paying 'lip service...to the concept of clinical freedom' while 'conformity and psychiatric domination of the drug misuse field remained the ultimate goals.'⁸⁰

Here then, was a department of the Home Office acting within the policy community in part to its own agenda. Spear, while concerned to control the flow of prescribed drugs from reaching the black market, part of the Home Office's remit for regulating doctors, also had a strong belief in the traditions of the 'British System' and the freedom it allowed to prescribers. Under his leadership, the Inspectorate allied with the London psychiatrists' interests of producing the *Guidelines* when seeking to reinforce its own policing powers, and opposed them when their policies were seen as too restrictive.

Outcomes

What the *Guidelines* said

In style and presentation the *Guidelines* were functional and unembellished. The text, broken into short paragraphs, was impersonal and detached, giving an impression of authority and consensus. It conveyed a sense that treating drug users was straightforward and relatively simple with limited variation. The content was targeted at the various doctors both inside and outside hospitals who might be involved in treating drug users, including general practitioners, psychiatrists and casualty officers. It focused on opiate, barbiturate and benzodiazepine dependence, with just a few sentences on alcohol, stimulants and other drugs.

⁷⁹ Senior Civil Servant, DHSS, (2001) *op. cit.*

⁸⁰ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.279.

The *Guidelines* told all doctors, including GPs, that it was their duty to provide care for their patients' drug related problems, a point emphasised in the covering letter from the Chief Medical Officer.⁸¹ Abstinence and cessation of injecting were the goals of treatment; long term opiate prescription was strongly discouraged and GPs were told to consider it only under the guidance of a specialist. The substitute drug of choice was oral methadone to be used only for withdrawal over no more than six months. Patient and doctor needed to agree the detoxification regime (but this is in an absence of any alternative prescribing). No concessions to injectable prescribing were made, although patients' dependence on 'injecting and injecting practice' were acknowledged. Doctors were also advised to consider prescribing non-controlled drugs instead of opioids to alleviate withdrawal symptoms.

An appendix 'Managing withdrawal symptoms and detoxification' set out various detoxification regimes for use inside and outside hospitals. Here too most attention was devoted to opioid, barbiturates and benzodiazepine dependence. For opioid withdrawal, no limit was set on the dose of methadone that could be prescribed but the suggestion was that doctors were unlikely to need to prescribe more than 80mg a day. Prescriptions of 80-100mg of methadone, the *Guidelines* advised, should not be attempted in outpatients. (The 1999 *Guidelines* recommended a daily limit of 120mg.⁸³) Prescribing regimes ranged between two weeks, which required the patient to be in stable accommodation and to receive intensive support from the doctor, and family or friends, to up to six months for which domestic stability was also needed. Daily dispensing to ensure the methadone was consumed only by the patient was encouraged.

As with other reports on drug treatment from the mid-1970s onwards, the 'multi-disciplinary' approach was advocated, both in hospital through team working and by liaison with other agencies.^{83,84} GPs were advised not to manage more chaotic patients or those on high doses but rather to refer them to hospital-based services. In short, doctors were advised on the range of prescribing they should and should not undertake, the type of patients they should take on or refer, the context in which they should prescribe, the acceptable drugs, doses, and formulations and their duties to drug using patients. This did not reflect agreement across the views of the Medical

⁸¹ E. D. Acheson, 'Guidelines of Good Clinical Practice in the Treatment of Drug Dependence' [letter to all doctors accompanying the *Guidelines*], (29th October 1984).

⁸² UK Health Departments, *Drug Misuse and Dependence. Guidelines on Clinical Management* (London: The Stationery Office, 1999) p.47

⁸³ eg. DHSS, *Better Services for the Mentally Ill* (London: HMSO, 1975) pp.68-70.

⁸⁴ eg. ACMD, (1982) *op. cit.*, pp.81-86.

Working Group, or the summation of research findings, but rather the dominance of some doctors' views over others.

Licensing

Licensing had first been introduced in 1968, on the recommendation of the second Brain Committee, so that doctors wanting to prescribe heroin or cocaine (and from 1984 dipipanone) for the treatment of addiction were required to apply to the Home Office (see Chapter 2).⁸⁵ These licences were almost exclusively granted to psychiatrists working in the new NHS Clinics. Only two or three doctors were ever licensed to prescribe heroin privately.^{86,87} This change was followed by a series of attempts, originating with the London Clinic consultants, to extend licensing and further restrict the prescribing powers of doctors outside the Clinic system. The case was made for this through concerns about the diversion of prescribed drugs onto the black market, blamed on doctors working outside the Clinics, and sometimes a disapproval of maintenance prescribing itself.

The first in this series of attempts occurred almost as soon as the Clinics had been set up and the first heroin and cocaine licences issued. A Department of Health meeting of the London Clinic psychiatrists in 1969 had proposed that *all* dependency producing drugs to known addicts, not just heroin and cocaine, should be removed from GPs and limited to the Clinics. However, the idea was rejected by the Department for financial reasons.⁸⁸ The idea was then revived at two meetings between the voluntary sector and consultants in 1979 and 1980, held at the Institute for the Study of Drug Dependence, aimed at providing recommendations for the ACMD's Treatment and Rehabilitation Working Group. The second meeting yielded a recommendation to extend licensing for doctors prescribing on a maintenance basis only to those working with or under a specialist facility. Although this recommendation seems to have misrepresented the views of a number of the voluntary sector agencies, it was forwarded to the ACMD nonetheless.⁸⁹ These then emerged only slightly modified in *Treatment and Rehabilitation* as recommendations for production of the Guidelines and to extend licensing to cover all opioid drugs (see Chapter 3 of the thesis).⁹⁰ Despite

⁸⁵ Interdepartmental Committee on Drug Addiction, *The Second Report of the Interdepartmental Committee* (London: HMSO, 1965) pp.9-10.

⁸⁶ Department of Health and Social Security, Department of Education and Science, Home Office and Manpower Services Commission, *Abuse of Drugs with Special Reference to the Treatment and Rehabilitation of Misusers of Hard Drugs: Government Response to the Fourth Report from the Social Services Committee Session 1984-85* (London: HMSO, 1985) pp.18-19.

⁸⁷ A. Macfarlane, Interview by Sarah Mars, (2002).

⁸⁸ J. L. Reed, "Meeting of Doctors Working in London Drug Dependency Treatment Centres, November 25th, 1969 at St Bartholomew's Hospital" [Minutes], Private Archive.

⁸⁹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.279-280.

⁹⁰ ACMD, (1982) *op. cit.*, p.84.

the Medical Working Group's majority support for the licensing extension, ministers at the Home Office and DHSS rejected the proposal.

It was an analysis of prescriptions for two opioids thought to be of most concern, *Palfium* and DF118s, which seems to have convinced Ray Witney, Parliamentary Under Secretary of State for Health, that these extra controls were not needed.⁷¹ However, the summary of the findings sent to David Mellor, his opposite number at the Home Office, advising against extending licensing, gave a somewhat partial and more optimistic interpretation than the prescribing figures in the accompanying table allowed (see table 8.1). This was then further exaggerated in Witney's covering letter, which referred to a 'downward trend since 1978' in dextromoramide (*Palfium*) and dihydrocodeine tartrate (DF118). DF118 prescribing had actually increased between 1974 and 1982 from 718 prescriptions to 944, followed by one year of slight decline to 922.

Table 4.1 Prescription Analysis: Opioids 1974-1983⁷²

Year	DF118 x 30mgms	<i>Palfium</i> x 10mgm	<i>Palfium</i> x 5mgm	<i>Palfium</i> 5mgm and 10mgm combined quantities
Number of prescriptions from 1:200 sample in thousands				
1974	718	(<i>Palfium</i> 10mg	75.3	4363
1975	713	not marketed	66.9	3990
1976	752	until 1978)	67.6	4450
1977	795		60.8	3675
1978	832	8.4	61.4	4483
1979	864	8.1	51.9	3633
1980	897	13.6	50.5	3934
1981	902	10.6	55.8	4225
1982	944	14.1	44.6	3687
1983	922	11.2	37.8	3268

⁷¹ R. Witney, Letter to D. Mellor, (22nd November 1985), File 16/DAC 28/2, DH Archive, Nelson, Lancashire.

⁷² Anonymous, 'Prescription analysis: opioids 1974-1983', Annex to R. Witney, (22nd November 1985) File 16/DAC 28/2, DH Archive, Nelson, Lancashire.

The prescription analysis document itself did not specify the source from which these figures were derived. Two possibilities existed: the controlled drugs registers held by pharmacists, which included details of every prescription issued whether private or NHS, but which were not held centrally, and the predecessor body to the Prescription Pricing Authority, which collected data on every prescription issued under the NHS for cost purposes. It was unlikely that the DHSS carried out its analysis of one in 200 prescriptions unless they were using the centrally held NHS information, therefore leaving private scripts out of the calculations. Any falls in the number of prescriptions for these opioids of concern, as was seen with *Palfium*, might therefore have represented the privatisation of its prescribing, the very issue which had prompted calls for the extension of licensing in the first place.

Ultimately David Mellor,⁹³ then Parliamentary Under Secretary of State at the Home Office, the Chief Medical Officer, Donald Acheson⁹⁴ and John Patten,⁹⁵ Parliamentary Under Secretary of State for Health, all agreed that licensing should not be extended. There was no indication that the prescribing policies pursued by the psychiatrists were influenced by politicians' views. After the major changes of the late 1960s and until 1981, prescribing policies were of very little political interest in the DHSS,⁹⁶ and the Home Office Inspectorate, while keeping a close eye on prescribing outside the Clinics, had made little use of the Tribunal system to discipline doctors.

While ministers at the DHSS did not take an interest in their content, they applied great pressure for speedy production of the *Guidelines* and preference was given to their completion over any consideration of licensing extension.⁹⁷ Evidence suggested, however, that the politicians' motive was to expand treatment provision amid heightened public concern about heroin, rather than to control prescribing, as the psychiatrists had intended. The *Guidelines* were presented by the Conservative Government as a plank in their response to the heroin epidemic of the early 1980s,⁹⁸ to encourage greater involvement of the medical profession in the care of drug users and so increase treatment provision.

⁹³ D. Mellor, (1985) *op. cit.*

⁹⁴ D. Acheson, Memo to Ms Bateman, (30th October 1985), File 16/DAC 28/2, DH Archive, Nelson, Lancashire.

⁹⁵ J. Patten, (1985) *op. cit.*

⁹⁶ Senior Civil Servant, DHSS, (2001) *op. cit.*

⁹⁷ eg. K. Clarke, 'Tackling drugs misuse', (31st October 1983), File DAC 14/4, DH Archive, Nelson, Lancashire.

⁹⁸ J. Patten, Thames Television, (1984).

Winners and Losers

The final version of the *Guidelines* fulfilled the aims of the London psychiatrists Philip Connell and Thomas Bewley. Long term maintenance prescribing was only to be undertaken by psychiatrists and GPs with specialist supervision experienced in that approach.⁹⁹ Although Thomas Bewley's first draft of the appendix was not used and Anthony Thorley, a young consultant psychiatrist working in Newcastle,^{100,101} was responsible for the final version, Bewley's overall prescribing preferences were reflected and abstinence was to be the clear strategy. The chapter 'Guidance for Psychiatrists' began by saying that 'Few psychiatrists have any specific training or wide experience in the treatment of drug misuse. Even fewer work in drug treatment units.' The deficiencies of psychiatric training were also referred to. Yet regardless of experience in drug and alcohol problems, it said, 'It is the responsibility of psychiatrists to ensure adequate arrangements for the necessary treatment and continuing care of those drug misusers referred to them, and in particular to provide advice and support for general practitioners in areas where there is no specialist drug treatment unit.' Another Bewley and Connell preference was reflected in the emphatically stated superiority of methadone over heroin. Even in hospitals 'there are no clinical grounds for heroin or an other opioid being prescribed' (except allergic reaction to methadone).

Arthur Banks was gratified by the *Guidelines'* initial statement that 'All doctors have a responsibility to provide care for both the general health needs of drug misusers and their drug related problems', going against the wishes of Dr Riddell, who opposed GP involvement. Although those opposing the extension of licensing to all opioid drugs lost the battle in the Working Group, they won the war when the status quo was preferred by ministers, probably on account of the Home Office's advice. In the *Guidelines*, the Home Office Drugs Inspectorate and the GMC gained a new medically authorised standard for prescribing which could be used in their regulatory work.

On the losing side, the AIDA, represented on the Medical Working Group by Ann Dally and Dale Beckett, expressed their views about the *Guidelines* in a document published the following year.¹⁰²

They criticised a number of its points, including the advice against prescribing substitute controlled drugs before assessment was completed. The underlying approach suggested by AIDA's criticisms was one which emphasised the individuality of patients, the high likelihood of failure in

⁹⁹ Medical Working Group on Drug Dependence, (1984) *op. cit.*, p.7.

¹⁰⁰ Senior Civil Servant, DHSS, (2001) *op. cit.*

¹⁰¹ A. Thorley, (2002) *op. cit.*

¹⁰² AIDA, 'Comments on "Guidelines of Good Clinical Practice in the Treatment of Drug Misuse" (DHSS 1984)', (1985) Ref. 44020, DrugScope Library, London.

detoxification, of drug dependence as a long term problem, the suffering resulting from withdrawal symptoms and the need to take into account addicts' immediate need or desire for a prescription.

Perhaps reflecting the different power relationship between the private doctor and his or her patient, the patient was seen as determining treatment to a greater extent than in the NHS. For instance, AIDA criticised the Clinics saying that 'addict in-patients who are not given the drugs they feel they need and with whom no rapport is made will either have drugs smuggled in or will discharge themselves, regardless of their physical health.'¹⁰³ All this pointed to more generous prescribing with the balance tipping more towards the individual patient than to public health or drug control concerns. In her autobiography, Dr Dally entitled her experience on the Medical Working Group 'The Misguidelines'.¹⁰⁴

Ann Dally's autobiography alleged that she and other 'dissidents' were tactically outmanoeuvred by the use of new committee procedures and so they were not allowed to register their opposition to the *Guidelines* through a minority report. This was confirmed by one of the consultant psychiatrist members who recollected a change in the committee rules side-stepping the need for final agreement, attributing this to behind-the-scenes activity by the Chairman and secretariat.¹⁰⁵ While the secretariat was influential in terms of members' selection and committee procedures, its limitations were perhaps revealed by the content of the *Guidelines*, which were less liberal than might have been expected from Dorothy Black's approach to prescribing.

The ACMD's *Treatment and Rehabilitation* expressed the intention, probably originating with Drs Bewley and Connell, that the *Guidelines* would be used as conditions for licences once the licensing system had been extended to cover all opioid drugs.¹⁰⁶ As this extension never took place, the *Guidelines* had less of a disciplinary role than originally intended. The London consultants did not admit defeat, however, and continued to re-introduce the idea of the licensing extension to government through the 1980s and '90s. These events are explored in Chapter 7.

What would appear to be a simple provision of guidance from 'experts' to other professionals raised many questions about both motives and methods. Like the *Treatment and Rehabilitation* report, it revealed the problematic nature of 'expertise' and evidence in a polarised and highly politicised field, the ways in which the medical profession has regulated itself, and the roles of government.

¹⁰³ *Ibid.* p.5.

¹⁰⁴ A. Dally, *A Doctor's Story* (London: Macmillan, 1990) p.127.

¹⁰⁵ A. Thorley, (2002) *op. cit.*

¹⁰⁶ ACMD, (1982) *op. cit.*, p.84.

Why impose one treatment model?

A question central to these political activities and considered by Stimson and Oppenheimer¹⁰⁷ and Spear¹⁰⁸ was why this particular group of psychiatrists placed so much importance on the universal adoption of their treatment model to the exclusion of all others.

The lack of research to support the change in the Clinics' prescribing policies was conceded by some of the key psychiatrists involved,¹⁰⁹ and another psychiatrist member of the *Guidelines* working party, and key advocate of its recommendations on the treatment of opiate addiction, described how they had come into being.

There was no question of a really serious long-term option of prescribing forever... That's something we were actually trying to stop... Because all over London there were these geriatric junkies to put it very rudely, people who had been prescribed out of the Sixties, were now into the Seventies, late Seventies, early Eighties, here we were, there's a rump of people who have just never changed, because, in a way they've never had sufficient sort of multidisciplinary support around them, and the sort of framework of prescribing to really encourage them to come off with the treatment and rehabilitation package that we'd been trying to advocate the year before... So, rather than again give these people in London, the London Harley Street stuff, [the private prescribers] a kind of green light to go on prescribing forever, we decided to have it self-limiting... And, of course there were three-month and six-month so-called detoxifications, which we did use in Newcastle. And, I mean they were reasonably successful. But of course this was all anecdotal. Nothing was tested with double-blind clinical trial. Everything was really opinion. Which of course was dangerous at one level.¹¹⁰

The 1984 *Guidelines* themselves were not 'evidence based', nor did they claim to be. They have since been retrospectively legitimised by the evidence based medicine movement, with an updated edition in 1991 and a complete re-write in 1999,^{111,112} but in their first incarnation were a summation of personal experience, hospital testing of treatment (not necessarily published) and various textbooks which might be the work of a single psychiatrist writing about his or her experience or what had been gathered from colleagues.

¹⁰⁷ G.V. Stimson and E. Oppenheimer, (1982) *op. cit.*, pp.215-219.

¹⁰⁸ H. B. Spear (and ed. J. Mott) (2002), *op. cit.*, pp.235-310.

¹⁰⁹ *Ibid.* pp.245-246.

¹¹⁰ A. Thorley, (2002) *op. cit.*

¹¹¹ Department of Health, Scottish Office Home and Health Department and Welsh Office, *Drug Misuse and Dependence. Guidelines on Clinical Management* (London: HMSO, 1991).

¹¹² UK Health Departments, (1999) *op. cit.*

At that time, the personal opinions and experience of senior doctors was considered a suitable basis for 'good practice' and in this sense they did not appeal to an external body of 'scientific' data to justify their statements, as Harrison and Ahmad have described in later guidelines.¹¹³ There was, in fact, little published research evidence on the efficacy of treatment at that time, but what there was, such as the Hartnoll and Mitcheson trial comparing heroin and methadone prescription was not considered in the *Guidelines*.¹¹⁴ The first *Guidelines* contained no references to scientific studies, only reports, textbooks or reference sources such as the British National Formulary.

Part of the change in Clinic prescribing policies which so influenced the *Guidelines* can be attributed to the 'silting up' of treatment spaces with long term maintenance patients and professionals frustrated at their lack of impact on their patients.¹¹⁵ Yet extraordinary measures were taken including attempting to get doctors disciplined if they opposed the newly favoured abstinence based approach. Struggles for prestige and status within the medical profession may explain this.

The new model of treatment (short term methadone detoxification and no injectable prescribing) described in the *Guidelines* allowed psychiatrists to achieve change in their patients, even if that change was short lived. Maintenance prescribing of injectable heroin, the drug that would have been used by the patient in the same formulation outside of treatment, could be seen as a passive professional approach, where any change in behaviour was initiated by the patient rather than the doctor. Clinic psychiatrists' favour of more 'active intervention' approach to treatment,¹¹⁶ where patients were given restricted options and required to sign contractual agreements, could be seen as an attempt to gain greater job satisfaction and prestige for their emerging specialty.

Stephen Shortell, writing in 1974, showed that the relative prestige of a specialty within the medical profession corresponded to the activity or passivity of the doctor in the therapeutic relationship. The more active the doctor was in relation to the patient, the higher the prestige of the specialty, with surgery, for instance, where the doctor would perform actively on the passive patient, scoring highly. The more the doctor relied on patient participation, and acted to 'help the patients help themselves', the lower the prestige.¹¹⁷ Prescribing oral methadone instead of injectable heroin was

¹¹³ S. Harrison and W.I.U. Ahmad, (2000) *op. cit.*, pp.129-146.

¹¹⁴ R. Hartnoll, M.C. Mitcheson, A. Battersby, *et al.*, 'Evaluation of heroin maintenance in controlled trial', *Archives of General Psychiatry*, 37 (1980), 877-884.

¹¹⁵ J. Strang, "'The British System': past, present and future", *International Review of Psychiatry*, 1 (1989), 109-120, p.116.

¹¹⁶ M. Mitcheson, (1994) *op. cit.*, p.189.

¹¹⁷ S. M. Shortell, 'Occupational prestige differences within the medical and allied health professions', *Social Science and Medicine*, 8 (1974), 1-9.

seen as more 'confrontational',¹¹⁸ therefore more therapeutic, offering the opportunity for addiction psychiatry to raise its low status in medicine and in psychiatry.

Another reason for this push towards treatment conformity arose from the social rationale for treatment approaches when used to control the drug supply. Since their inception, the Clinics had intended to prevent the spread of addiction by controlling the supply of prescribed pharmaceuticals and in this may have existed the essential incompatibility of the treatment approaches themselves when used for this purpose. While a doctor who prescribed liberally might have coexisted unproblematically with other services which only offered detoxification, one who considered that detoxification was the sole valid approach might view the existence of other services providing long term prescription as undermining his or her work. This desire to standardise practice was one reason that the London consultant psychiatrists met regularly at the Home Office: 'Most of us took the view that we all needed to do much the same thing, so that people couldn't work their way round to find the most liberal prescriber.'¹¹⁹ It also helped overcome their isolation and enabled them to share practical information. Thomas Bewley made clear that a contributing factor in ceasing injectable prescribing was because his colleagues were doing so, 'It would have been quite difficult for one consultant to prescribe in a markedly different way to the other units.'¹²⁰

Thus Clinic services believed they needed to present a united front so that they *all* offered only short-term detoxification. Patients seeking treatment would then be forced down this path for their own benefit. If one service stepped out of line, patients would inevitably be attracted away by the offer of prescribed drugs, risking overdose, selling their surplus drugs, or deepening their dependence, pushing their tolerance and dose higher and making eventual detoxification more difficult.

The implicit behavioural model here was one where drug users were unable to judge their own interest and required a paternalist approach, and certainly one where they should not be subjected to the 'temptation' of larger scripts.¹²¹ This might have been more typical of the specialty of psychiatry, where patients were more likely to be seen as not knowing what is in their best interest and there being greater potential for disagreement between patient and doctor on the diagnosis and appropriate treatment. It was, after all, one of the only areas of medicine where a patient could be detained against his or her will for treatment.

¹¹⁸ G.V. Stimson and E. Oppenheimer, (1982) *op. cit.*, pp.215-219.

¹¹⁹ T. Bewley, (2001) *op. cit.*

¹²⁰ Anonymous, 'Journal Interview 36: Conversation with Thomas Bewley', *Addiction*, 90 (1995), 883-892, p.885.

¹²¹ A. Thorley, (2002) *op. cit.*

A treatment that provided choice regarding prescribing might instead have seen them as 'consumers', more compatible with the concept of a medical market place inhabited by private practitioners. Some doctors such as Dale Beckett, the addiction consultant at Cane Hill Hospital, who was outside the London psychiatric establishment and had worked in both the private sector and NHS, questioned the very role of the state in controlling access to drugs.¹²²

Of course, a united front could have offered a more liberal rather than a more restrictive prescribing regime across the board, but it is worth remembering that drug use was seen by some medical professionals as a moral issue, arousing strong disapproval. Thomas Bewley, an important member of the Medical Working Group, described his own misgivings about the 'sinfulness of pleasure' from drug use in an article in 1970.¹²³ His comment that 'we're not in the business of prescribing happiness drugs',¹²⁴ in explanation for his refusal to prescribe cocaine or amphetamines, might have also explained his strong preference for methadone over heroin in the early 1980s. James Willis, a dissenting London psychiatric consultant, also attributed the move away from maintenance heroin prescription as partially due to doctors' tendency 'to moralise about their fellow creatures'.¹²⁵

The tendency to standardise treatment across the Clinics towards the end of the 1970s was accompanied by an increased application of bureaucratic rules,^{126,127} including contractual agreements between patients and staff regarding attendance and a number of other areas which had previously been subject to individual judgement.¹²⁸ The London psychiatrists' success in imposing bureaucratic rules on their Clinics could partly be attributed to the lack of counterbalancing forces. Demands for services to be designed around the drug users' preferences rather than those of the providers were hardly heard within the Clinics at this time. Drug users have only recently, and sporadically from the late 1980s, organised themselves to lobby for their interests in treatment. Indeed, some evidence has suggested that patient autonomy was actively resisted by doctors working in the field through the universal treatment model.¹²⁹ Patients' voices were weak because

¹²² H. D. Beckett, (2001) *op. cit.*

¹²³ T. H. Bewley and R. S. Fleminger, 'Staff/patient problems in drug dependence treatment clinics', *Journal of Psychosomatic Research*, 14 (1970), 303-6, p.306.

¹²⁴ T. Bewley, (2001), *op. cit.*

¹²⁵ J.H. Willis, 'Unacceptable face of private practice: prescription of controlled drugs to addicts' [letter], *British Medical Journal*, 287 (1983), 500.

¹²⁶ Patient Interview 2 by Sarah Mars, (2002).

¹²⁷ A. Thorley, (2002) *op. cit.*

¹²⁸ *Ibid.*

¹²⁹ V. Berridge, 'AIDS and the rise of the patient? Activist organisation and HIV/AIDS in the UK in the 1980s and 1990s', *Medizin Gesellschaft und Geschichte*, 21 (2002), 109-23.

of their socially stigmatised status, poor collective organisation, desire for confidentiality and fear of losing their supply of prescription drugs. Clinic services were therefore not planned around the priorities of their users.

At the other extreme, private medicine, being more market led, was more clearly influenced by patient preference. As very small organisations, private and general practices did not require bureaucratised systems and operated as individual businesses with non-standardised codes of behaviour. Some attempts were made to bring peer influence to bear among this disparate group in the 1980s by the AIDA through the expulsion of members thought to be practising poorly, but it failed to get concerted support among private doctors and the organisation stopped meeting in 1988 (see Chapter 8).

Some have seen the proliferation of clinical guidelines as a symptom of decreasing medical autonomy and bureaucratisation resulting from employment by the state and consequent diminution of professional status.¹³⁰ While the Clinics had undoubtedly become increasingly bureaucratic, the use of bureaucratic rules actually served the leaders of the psychiatrists in their self-regulation to preserve and extend their prestige and their control over doctors outside the Clinics.

Concern about 'diverted' pharmaceuticals

'Diverted' pharmaceutical drugs, which were consumed by someone other than the prescribed patient, caused ongoing concern after the second Brain Committee attributed to them the growth in recorded drug addiction in 1965. They formed a major part of the argument in favour of controlling the prescribing of doctors outside the Clinics,¹³¹ yet during the 1980s, this market was dwarfed by the large amount of trafficked heroin entering the country. One might therefore wonder why this relatively small market caused so much disquiet and prompted the range of measures proposed by the *Treatment and Rehabilitation* report, including the *Guidelines*. Was it simply ammunition for those doctors pressing for stricter prescribing to use against those not conforming to their treatment model or were there other reasons?

A visible market existed in diverted pharmaceuticals in London, to which attention was drawn by anthropologist Angela Burr in 1983.¹³² This public revelation was seen as a threat to the perceived

¹³⁰ S. Harrison and W. I. U. Ahmad, (2000) *op. cit.*, pp.129-146.

¹³¹ ACMD, (1982) *op. cit.*, pp.51-62.

¹³² A. Burr, 'The Piccadilly drug scene', *British Journal of Addiction*, 78, 1 (1983), 5-19.

professionalism of doctors. In addition, there was evidence that major change could be achieved in reducing the supply of diverted pharmaceuticals, as had occurred with the amphetamine *Melbedrine*, which, with the help of its manufacturers, had disappeared from the illicit drug scene by 1968.¹³³ Finally, unlike less tangible components of doctors' practice, prescribing was quantifiable and so more easily subject to standardisation.

Conclusion

The origin of the *Guidelines* lay in the medical profession's claim to the sole right to determine treatment, as asserted by a psychiatrist member of the Treatment and Rehabilitation Working Group. In this doctors successfully defended their right to collective clinical autonomy against potential incursions from outside medicine. At the same time they were strengthening their collective clinical autonomy through the control, in the form of the *Guidelines*, of other doctors' individual clinical autonomy.

Klein has described a similar situation after the 1991 NHS market reforms that witnessed the proliferation of clinical guidelines and protocols. Here the individual autonomy of NHS consultants was shrinking while they accepted greater collective responsibility.¹³⁴ However, in this case, the *Guidelines* were aimed not at regulating the addiction psychiatrists or the profession as a whole, but the small number of private prescribers practising in London.^{135,136} Significantly, the Working Group responsible for drafting *Treatment and Rehabilitation* contained four consultant psychiatrists and one NHS general practitioner but no private doctors.

The *Guidelines* were the result of a range of interested parties struggling to get their approach adopted as 'good practice', and appearing as a consensus statement from the profession. This was not new in the formation of *Guidelines*. Jennifer Stanton's work on the development of Hepatitis B vaccine policy guidelines showed how the epidemiology and potency of the disease played some part, but were not the chief determinants of policy.¹³⁷ In the case of the treatment of drug users, not only was research evidence on the efficacy of treatments very limited at that time, but there was also a lack of agreement within the profession on what drug dependence actually meant, and doctors' roles in relation to the drug supply.

¹³³ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.218-222.

¹³⁴ R. Klein, *The New Politics of the National Health Service*, (London and New York: Longman, first published 1983, third edition 1995) pp.243-244.

¹³⁵ A. Thorley, (2002) *op. cit.*

¹³⁶ Senior Civil Servant, DHSS, (2001) *op. cit.*

¹³⁷ J. Stanton, 'What shapes vaccine policy? The case of hepatitis B in the UK', *Social History of Medicine*, 7, 3 (1994), 427-446.

The *Guidelines* showed the struggle for dominance of one treatment model – that of the London psychiatric establishment – against a range of interests represented in the Medical Working Group, and its alliance with the bureaucratic interests of the state to achieve this. While presented as a way of encouraging doctors to treat drug users, they were originally intended to be used for disciplining doctors, particularly private prescribers, who did not follow them, and were later employed for this purpose.

The *Guidelines* were the codification of a change of practice achieved informally through peer pressure among the London Clinics, which could offer addiction psychiatry greater professional prestige and sense of achievement in their work. The Clinics' policies had not been driven by research on treatment effectiveness, but were justified retrospectively through the misrepresentation of one particular piece of research, the Hartnoll-Mitcheson trial. While this change of practice had been achieved informally through face-to-face contact among the London psychiatrists, it faced resistance and challenge from doctors outside, who, in turn, used little published evidence to justify their own positions. The *Guidelines* embodied the extension of this pressure towards prescribing conformity to doctors outside the Clinics, with the authority of medical 'consensus', and the threat of enforcement by the Home Office Drugs Inspectorate.

Chapter 5

Major Regulatory Interventions II:

The Dally Cases (1983-88) and the General Medical Council

Introduction

This chapter considers the role of the General Medical Council (GMC) in disciplining doctors, and in particular, its activities in the relationship between private and NHS drug doctors. The high profile case of Ann Dally, the best known private prescriber of the 1980s, and president of the Association of Independent Doctors in Addiction (AIDA) forms the focus.

Dr Dally was first brought before the Council on charges of serious professional misconduct in 1983. After being found guilty and admonished, a second case was brought against her in 1986. Found guilty again in January 1987, this time she was banned from prescribing controlled drugs for 14 months and the case was resumed at the end of this period resulting in her registration to the medical register being fully restored in November 1988.

Since a survey of all the cases of private prescribers taken before the GMC between 1970 and 1999 would have been too great a task for this research project, and because it could be argued that Ann Dally was untypical of the other such doctors, a second case has been studied for comparison. Dr Herman Peter Tarnesby was taken before the GMC in 1984, a year after the Home Office Drugs Inspectorate had taken him to a Tribunal that had found him guilty of irresponsible prescribing.¹

The General Medical Council

In the nineteenth century doctors arranged themselves into bodies to represent and regulate themselves in the British Medical Association and GMC (GMC) respectively. The state supported this self-regulation in the 1858 Medical Act establishing the GMC as a formal medical register to identify qualified doctors and giving the Council jurisdiction over professional conduct, with powers similar to a legal tribunal.² The main motivation for self-regulation appears to have been

¹ Home Office Inspector, Interview by Sarah Mars, (2002).

² R. G. Smith, *Medical Discipline. The Professional Conduct Jurisdiction of the General Medical Council, 1858-1990* (Oxford: Oxford University Press, 1994) pp.1-31.

reducing competition between health care workers in an overcrowded market over and above the protection of public interests.³

The mechanisms and motives of professional self-regulation have been extensively considered by social scientists and historians of medicine (see Chapter 1). Since the Second World War commentators have been notably sceptical about the profession's lofty declared aims, seeing its special status mainly as a mechanism for the monopolistic restriction of the market. Medical ethics have been described as simply 'politics by other means', a way of gaining respectful deference from patients and exempting the profession from various external political and legal controls, while legitimising its rights to self-government and self-policing.⁴⁵

During the period under study, the GMC underwent major changes, some inwardly driven, others from outside. Some of these changes derived from major cultural shifts that took place across Western societies from the 1960s, influencing at different rates, a whole range of social and economic relationships, including those between doctors and patients. Civil rights movements across the world challenged accepted social norms and the intellectual anti-psychiatry movement asserted that many mental 'illnesses' were socially constructed, questioning the basis of medical power.

Inside the medical profession, the early 1970s saw a crisis precipitated by major dissatisfaction with the representativeness of the Council, a new annual membership fee, and the treatment of overseas doctors. This led to a government inquiry, the Morrison Committee, which reported in 1975, culminating in the 1978 Medical Act. This Act increased the proportion of elected members on the Council, doubling its size and extending its function. Discipline was, for the first time, divided into 'professional conduct' and 'health', distinguishing the 'bad' from the 'mad'.⁶

Accordingly, the Council's disciplinary roles from the 1980s were exercised through the Preliminary Proceedings Committee (PPC), the Professional Conduct Committee (PCC), and the Health Committee. The Preliminary Proceedings Committee decided whether cases of alleged serious professional misconduct should be referred to the PCC for full public hearing. The latter had the

³ M. Stacey, *Regulating British Medicine: the General Medical Council*, (Chichester: John Wiley and Sons, 1992) pp. 16-17.

⁴ R. Cooter, 'The ethical body', in R. Cooter and J. Pickstone (eds.) *Medicine in the Twentieth Century*, (Amsterdam: Harwood Academic Publishers, 2000) pp. 457-460.

⁵ R. Porter, 'Thomas Gisborne: Physicians, Christians and Gentlemen' in A. Wear, J. Geyer Kordesch and R. French (eds.) *Doctors and Ethics: The Earlier Historical Setting of Professional Ethics*, (Amsterdam and Atlanta: Rodopi, 1993) pp. 252-273.

⁶ M. Stacey, (1992) *op. cit.*, p. 173.

power to erase a doctor's name from the register, suspend registration, impose conditions upon further registration or refer the case to the Health Committee.⁷

From 1970, the GMC had taken the view that prescribing or supplying drugs of dependence 'other than in the course of *bona fide* treatment' constituted serious professional misconduct.⁸ From 1973 until 1997, disciplinary action against doctors prescribing controlled drugs was dealt with by both the Home Office Drugs Inspectorate (the Inspectorate) and the GMC, with some ambiguity over responsibility. Following the 1993-97 Garfoot Case and Dr Garfoot's successful appeal against its ruling, the Home Office sent fewer inspectors to visit doctors (see Chapter 6) and ceased using Tribunals to stop their prescribing. The GMC continued to rely upon the Inspectorate for evidence against doctors, but formally enforcing professional standards for prescribing controlled drugs fell to the GMC alone.

It appeared that in the 1970s and earlier, the GMC felt reluctant to get involved in cases concerning errors in diagnosis or treatment, or in fact any issue that bordered on doctors' clinical autonomy.⁹ This might have explained the GMC's desire to avoid prescribing cases, even when there was no alternative option of a Home Office Tribunal. The cause of its greater alacrity towards alleged irresponsible prescribers in the 1980s may have in part reflected wider pressures on the Council to scrutinize more closely its members' conduct. Stacey described a range of forces attacking the GMC during the 1980s, pushing for more responsive and transparent self-regulation and at times for the end of self-regulation itself.¹⁰ These were the media, patient groups, politicians and the radical Right.

A number of high profile journalist investigations into the Council's disciplinary workings were broadcast on television, including a series by Esther Rantzen in 1983 that resulted in changes to the GMC's official guidance to doctors. Patient pressure groups became more radical and outspoken in their criticisms. In 1984 Labour MP Nigel Spearing tried to get a private members bill passed to introduce a second, lesser charge of 'unacceptable medical conduct' and thus widen the number of cases considered by the Professional Conduct Committee. Although successfully opposed by the GMC, ministers took a keen interest in the issues and the GMC was compelled to respond to criticisms. To forestall this externally developed legislation being passed, the GMC developed its

⁷ R. G. Smith, (1994) *op. cit.*, pp.149-197.

⁸ H. B. Spear (and ed. J. Mott), *Heroin Addiction Care and Control: The 'British System' 1916-1984* (London: DrugScope, 2002) p.64.

⁹ M. Stacey, (1992) *op. cit.*, pp.173; 184.

¹⁰ *Ibid.* pp.181-199.

own scheme to extend its own powers in disciplinary cases that was eventually passed in legislation in 1995.¹¹ Stacey remarked of the 1984 events, 'Neither the Houses of Parliament nor the civil service formerly concerned themselves with the workings of the GMC (or any other professions), but times had changed.'¹²

These developments pushed the GMC into a defensive position in which it increased the number of cases it dealt with concerning conduct issues in the 1980s and '90s,¹³ and may have provided the opportunity for those interests in the drugs field keen to exercise self-regulation for their own particular concerns.

Treatment of Drug Dependence: Clinical Autonomy and Constraints

The law has taken a limited role in controlling the specific treatments given by doctors to drug users in the treatment of addiction in England, in contrast with the United States, where, from 1974, statute specified the formulation and drugs to be prescribed (oral methadone and more recently, buprenorphine), their formulations, the settings in which they could be prescribed and how they should be dispensed.

After 1973, the Home Office had statutory powers to control the prescribing of doctors through its Tribunal system that had been reintroduced after an absence of 12 years.¹⁴ The system was used exclusively against GPs and private doctors and never against any doctor working in the hospital-based psychiatry-led Drug Dependence Units on matters of 'irresponsible prescribing' (see Chapter 6).^{15,16,17} However, there were cases, such as Ann Dally's, where evidence gathered by the Home Office for a Tribunal was used instead by the GMC.

According to Bing Spear, employed at the Home Office Drugs Branch from 1952-86, and Chief Inspector from 1977, the Council was reluctant to deal with the issue of prescribing to drug users from the 1940s right up to 1970, wishing the Home Office to restore its Tribunal system instead.¹⁸

¹¹ M. Stacey, 'The General Medical Council and Professional Self-Regulation', in *Regulating Doctors*, ed. D. Gladstone, (London: Institute for the Study of Civil Society, 2000) pp.28-39.

¹² M. Stacey, (1992) *op. cit.*, pp.184-185.

¹³ *Ibid.* pp.181-199.

¹⁴ P. Bean, 'Policing the medical profession: the use of tribunals', in D. K. Whynes and P. T. Bean (eds.), *Policing and Prescribing: The British System of Drug Control* (London: Macmillan, 1991) pp.60-70.

¹⁵ Home Office Inspector, (2002) *op. cit.*

¹⁶ Home Office, 'The Misuse of Drugs Act 1971, Section 13, List of practitioners (doctors, dentists and veterinarians) who are subject to a direction of the Secretary of State prohibiting them from prescribing, administering and supplying and from authorising the administration and supply of such controlled drugs as may be specified in the direction' (Home Office, 2002).

¹⁷ P. Bean, (1991) *op. cit.*, p.65.

¹⁸ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.218-223.

In 1967/8 the GMC had not taken action against the private prescriber, Dr John Petro, who had aroused great tabloid interest by prescribing in London's underground stations and other public places, waiting instead for the Courts to act, and only erasing him from the register after the Home Secretary had withdrawn his powers to prescribe 'dangerous drugs'. Even then, a delay between the GMC's ruling to erase Petro from the register, and his appeal hearing five months later allowed the doctor to continue prescribing the amphetamine *Metbedrine*. The Council had been 'greatly criticised' for the delay, and the loophole was closed by the 1969 Medical Act.^{19,20}

Russell Smith's quantitative analysis of the GMC's disciplinary activities led him to observe that it was only after 1969 that the GMC began to deal with cases of drug prescription any more than rarely, and he speculated that this could have reflected the increased incidence of drug use in the community.²¹ Drug use and dependence undoubtedly became more common around this point, rising from initially tiny numbers throughout the 1960s,²² and it was also a time of increased public and media concern, which had in turn prompted a re-convening of the Brain Committee to investigate (see Chapter 2). Its findings, that leakage from over-prescribing doctors was providing the source of a black market in drugs and stimulating addiction, brought about the major changes in treatment services and legislation of the late 1960s,²³ establishing the Clinics and nurturing the new group of addiction psychiatrists.

Although the GMC increased the number of cases it dealt with after 1969, this did not reflect any greater enthusiasm for the issue in the early 1970s. In 1971, Lord Cohen, then President of the GMC, spoke during the passage of the Misuse of Drugs Bill in the House of Lords, saying that without an extension of its jurisdiction by statute and increased financial support the Council could not investigate these cases, as 'we are not a police force; we have no inspectorate'. He urged the House to reintroduce a Tribunal system, which it did in the passage of the Bill.²⁴ It seemed likely that the objection of having no police force was a lobbying tactic to bring back Tribunals, rather than based in any desire to rectify this. In 1975, the Merrison Inquiry recommended that the GMC

¹⁹ Hansard, House of Lords, (14th January 1971), Vol 314, col. 248.

²⁰ R. G. Smith, (1994) *op. cit* p.180.

²¹ *Ibid.* pp.103-4; 110.

²² D. Hawks, 'The dimensions of drug dependence in the United Kingdom' in G. Edwards, M. A. H. Russell, D. Hawks *et al* (eds.), *Drug and Drug Dependence* (Farnborough, Hants., England: Saxon House and Lexington, Mass., USA: Lexington Books, 1976) pp.7-10.

²³ Interdepartmental Committee on Drug Addiction, *The Second Report of the Interdepartmental Committee* (London: HMSO, 1965).

²⁴ Hansard, House of Lords, (14th January 1971), Vol 314, col. 245.

set up its own investigation unit to research allegations against doctors,²⁵ but the Council rejected the idea as inappropriate to its role.²⁶

The GMC's guidance on the treatment of drug dependence was very limited throughout the period. Ann Dally reported writing to the GMC in August 1982 asking for advice on the treatment of addicts in private practice. She quoted the reply as stating 'the Council has hitherto issued no specific guidance' on that subject.²⁷ Smith confirmed this: the GMC's *Professional Conduct and Fitness to Practice* only referred to 'the prescription or supply of drugs of dependence otherwise than in the course of bona fide treatment'.²⁸ From 1981 to 1985 the Council's Standards Committee was considering issuing further advice on prescribing opioid drugs, particularly in private practice but seemed unable to reach a decision. When called to account by the House of Commons Social Services Committee in 1985, GMC representatives cited the Department of Health's 1984 good practice guidelines as sufficient to set out 'a corporate view of what constitutes proper practice in this field'.^{29,30}

Relations between the GMC and the State

The ability of the medical profession to self-regulate was based upon the idea that only a doctor's peers were capable of judging performance. Over the last three decades of the twentieth century, doctors attempted to defend this principle, while under increasing pressure. Patients, the media and later the government challenged the exclusivity of medical expertise and in 1979 the GMC increased its lay membership (although the actual lay proportion fell). While the GMC expanded its areas of responsibility, the profession also became subject to a number of state and supra-state bodies, such as the European Union.

As Stacey has noted, the relationship between the GMC and the state has been a complex one. Although independent of direct government control, it was also 'part of the apparatus of the central state'.³¹ The NHS would only employ doctors registered with the GMC (not technically a

²⁵ Committee of Inquiry into the Regulation of the Medical Profession, *Report of the Committee of Inquiry into the Regulation of the Medical Profession* [Merrison Report] (London: HMSO, 1975) p.87.

²⁶ M. Stacey, (1992) *op. cit.*, pp.28-39.

²⁷ A. Dally, *A Doctor's Story* (London: Macmillan, 1990) p.113.

²⁸ R. G. Smith, (1994) p.39.

²⁹ House of Commons Social Services Committee, *Fourth Report: Misuse of Drugs with Special Reference to the Treatment and Rehabilitation of Misusers of Hard Drugs*, Session 1984-85, (London: HMSO, 1985) pp.67-68.

³⁰ Medical Working Group on Drug Dependence, *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* (London: DHSS, 1984).

³¹ M. Stacey, (1992) *op. cit.*, p.13.

requirement in the private sector),¹² and when large numbers of NHS doctors faced erasure from the register for refusal to pay the new annual fee in the early 1970s, the threat this posed to the NHS prompted the government to set up the public inquiry under the chairmanship of A W Merrison. In 1974 medicine successfully defended itself from regulation by the NHS, and repeated this with the 1978 Medical Act, which was based largely on the findings of the Merrison Committee, but external scrutiny of the Council continued.

Throughout the period the Department of Health and Health Authorities as employers or contractors could exercise certain controls over National Health Service doctors, but had no such powers over private doctors. In the special area of controlled drugs, the Home Office's Inspectorate also represented regulation by the state, but the Tribunals that delivered its ultimate sanctions were medical in membership and constituted to reflect the accused doctor's area of practice, ie primary or specialist sectors, although witnesses could be from either. As one inspector stated at a GMC hearing, it was not his place to judge prescribing, 'It is for the tribunal to determine whether a doctor has been irresponsible. We merely gather the evidence.'¹³ From 1973-1997, unless a doctor had been convicted of a criminal offence in the Courts, the Home Office could therefore put no curbs on his or her prescribing without the agreement of other doctors.

The seventeen years of Conservative Government and its relations with the medical profession revealed contradictory impulses within the British right wing. On the one hand, Margaret Thatcher's governments professed allegiance to the free market, and accordingly it clashed with the professions over their monopolistic practices.¹⁴ The daughter of a grocer, Thatcher promulgated a radical social agenda that did not accept as given the privileged position of professionals and her stance tapped into a wider suspicion of hierarchy and deference. The Office of Fair Trading made investigations into restrictive practices of the GMC, followed by referral of the case to the Monopolies and Mergers Commission and led to the GMC revising its guidance on advertising in 1990.

Along with the free market, came the exaltation of 'choice' and the supremacy of the consumer. From 1989 the Government attempt to further extend consumer choice over the heads of the wishes of doctors with the introduction of an 'internal market' into the NHS. However, while

¹² Without GMC registration it is not an offence to practice medicine, only to claim to be a 'registered medical practitioner'.

¹³ GMC, Professional Conduct Committee, Day One, (9th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.1/29.

¹⁴ M. Stacey, (2000) *op. cit.*, pp.28-39.

other areas of the NHS saw a rise of consumerism, drug treatment remained resistant to consumer demand. The emergence of voluntary sector patient pressure groups and services could be interpreted as expanding consumer demand and choice, a role supported by state funding for many charities and non-profit providers in the 1980s.

However, a completely free market in health care was not politically viable and to achieve many of their policy goals the Conservatives moved in quite the opposite direction by centralising NHS controls and bureaucracy in the 1980s and '90s, heightening the contrast with the private sector. Cooter observed this as a disintegration of the autonomous power of the medical profession, and a gradual withdrawal of the state's compliance in the profession's own ethical governance,¹⁵ in contrast with Klein's view of the medical profession as accepting and participating in the restriction of individual clinicians' autonomy in order to strengthen collective professional autonomy.¹⁶

Within the GMC the dominance of NHS members could be perceived, as during the 1980s drug treatment expertise was recognised almost exclusively as residing among the NHS Clinics. The dominance of NHS doctors within the GMC was the mirror image of the pharmaceutical profession, where the more numerous and better represented small business pharmacists dominated the salaried NHS employees in its professional bodies and in policy-making.¹⁷ This NHS dominance applied less in the Inspectorate, which, although using advice from NHS psychiatrists, tended to formulate its own independent views (discussed further in Chapter 6).

The 1997 Labour government withdrew many of the previous government's market reforms as unpopular but the rallying cries of consumer choice and medical accountability remained popular. By positioning itself under the banner of the consumer's champion, New Labour could be seen as appealing across the electorate, neither focusing on 'old' Labour's 'workers' nor the Conservative's industry and business, while antagonising neither, and under Prime Minister Tony Blair it continued its attempts to regulate medicine. Cooter has convincingly argued that the consumerist movement of the 1970s and '80s broadened the base for participation in medical ethical thought, rhetoric and action, so that the turn of the twenty-first century saw the highest ever levels of claims for legal redress for unethical medical procedures and calls for statutory regulation to protect against

¹⁵ R. Cooter, (2000) *op. cit.*, pp.451-468.

¹⁶ R. Klein, *The New Politics of the National Health Service*, (London and New York: Longman, first published 1983, third edition 1995) pp.243-244.

¹⁷ S. Anderson, 'Health professionals and health care systems: the role of the state in the development of community pharmacy in Great Britain 1900 to 1990', *National Health Policies in Context Workshop*, (Bergen, Norway, 27-28th March 2003).

unethical practices.³⁸ Government attempts at control became more overt in the late 1990s as several high profile 'scandals', such as the high patient death rate in paediatric cardiac surgery at Bristol Royal Infirmary, were cited as justification for state regulation. The GMC in turn, under government, media and public scrutiny, wished to be seen to be doing its job of regulation, and stepped up its activities considerably, which by the end of the century, were having a dramatic impact on private doctors prescribing to drug users.

Relations between the GMC and the Inspectorate

With the GMC responsible for all medical discipline including prescribing and the Home Office Inspectorate concerned specifically with controlled drugs, it was unclear during this period which body should take the lead. Despite Lord Cohen's declared distaste for dealing with this topic, ways of working seem to have developed between the Council and the Inspectorate without being made explicit by either side.

As has been noted, the key difference between the bodies was that the GMC lacked inspectors to gather evidence for its hearings. Members of the Inspectorate commented that the GMC relied upon it for its information and to take the lead in Tribunals. According to an inspector working since the early 1980s, the GMC 'saw us as in a sense doing their dirty work', a view Bing Spear, Chief Inspector at the Home Office, reportedly shared at the time.^{39,40} Information flowed from the Inspectorate to the GMC but not in the other direction.⁴¹

In spite of Spear's gratification over the restored Tribunal system, it was only used nine times between 1974 and 1982. In contrast the GMC Professional Conduct Committee heard 39 cases of 'improper' prescribing and erased 18 doctors from the medical register between 1972 and 1984.^{42,43} Between 1983 and 1989 the GMC greatly increased its non bona fide prescribing cases that reached 46 in 6 years.⁴⁴ These figures are difficult to interpret, however, since both tallies included doctors who had committed offences under the Misuse of Drugs Act as well as those whose manner of prescribing was considered problematic but not criminal, and they do not show the spread of cases within each period. Furthermore they both included self-prescribing by addicted doctors, although

³⁸ R. Cooter, (2000) *op. cit.*, pp.458-460.

³⁹ Home Office Inspector, (2002) *op. cit.*

⁴⁰ eg. A. Dally, (1990) *op. cit.*, p.134.

⁴¹ Home Office Inspector, (2002) *op. cit.*

⁴² H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.63.

⁴³ House of Commons Social Services Committee, (1985) *op. cit.*, p.68.

⁴⁴ M. Stacey, (1992) *op. cit.*, p.163.

from 1980 the GMC dealt with cases of addicted doctors by referring them to its Health Committee.

In 1982 the ACMD's report *Treatment and Rehabilitation* criticised the Home Office for under using its Tribunal machinery. Bing Spear, in his evidence before the GMC at Ann Dally's first case, stated that the reason for this was that the law empowered the Home Office to take action against 'irresponsible' prescribing, which it had not defined, rather than 'over-prescribing'. 'Over-prescribing is not necessarily irresponsible prescribing because if it were I think we would have Tribunals running 365 days a year.'⁴⁵ However, the Home Office responded to the criticism and from 1982 the Tribunals became much more frequent, with 4 in 1984.⁴⁶ Unlike the GMC, who did not visit doctors in advance of initiating proceedings, the Inspectorate could use the threat of a Tribunal to influence practitioners, allowing it a more informal regulatory role.

The ambiguity over the GMC and Inspectorate's roles could produce the strange situation of a double trial, as seen with Dr Tarnesby (below), where the doctor was taken before a Home Office Tribunal, his prescribing powers curbed, and then taken before the GMC to be tried on the same evidence. On occasion, as in Ann Dally's second GMC case, the Council took up cases that the Home Office had declined to put to Tribunal, but the explanations for this were unclear. Much of the evidence given against Ann Dally in her GMC hearings was gathered by Home Office inspectors either through interviews or records of her prescribing patterns kept by pharmacies.

While the Home Office automatically informed the GMC when a doctor had been convicted in criminal court, information about a Tribunal ruling would not necessarily be provided.⁴⁷ Reversal of GMC and Home Office sanctions were independent of each other, so that a doctor who had been erased or suspended from the medical register by the GMC and had their controlled drugs licence suspended by a Home Office Tribunal, could be re-registered by the GMC on an appeal or at the end of their suspension, and would have to apply separately to the Home Office to regain their controlled drugs privileges. The Home Office could therefore withhold controlled drugs prescribing from a re-registered doctor. If working together, the GMC could re-register a doctor on the understanding that the Home Office would retain its ban on controlled drug prescription.⁴⁸

⁴⁵ GMC Professional Conduct Committee, Day Two. (6 July 1983), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.2/57.

⁴⁶ House of Commons Social Services Committee, (1985) *op. cit.*, pp. 167-187.

⁴⁷ *Ibid.* pp.67-76.

⁴⁸ R. G. Smith, (1994) *op. cit.*, p.217.

After the Dr Adrian Garfoot's successful appeal against the Home Office (see Chapter 6), the Inspectorate ceased using Tribunals and started to move away from policing doctors, carrying out far fewer interviews.⁴⁹ Without the threat of the Tribunal they could only hand over information they collected to the GMC for action. Like the GMC, the alacrity with which the Inspectorate pursued private doctors to Tribunal and through other routes varied between the 1970s and '90s as the Inspectorate housed a range of views which are discussed in detail in Chapter 6.

The Inspectorate was an enthusiastic regulator throughout this period, using informal methods of persuasion in the early 1970s, while pressing for the return of its formal Tribunal machinery. The GMC supported these calls in order to relieve it of its own obligations, though still prosecuting cases somewhat reluctantly. Once granted the desired formal mechanisms, the Inspectorate used them sparingly until the early 1980s, when both regulators increased their levels of formal prosecutions, with the GMC reliant on the Inspectorate for evidence. In the late 1990s the Council overtook the Home Office in both zeal and powers, as the Inspectorate once more lost its Tribunal machinery and was forced to return to its less formal methods of advising doctors and acting as the GMC's intelligence arm. The cases of Ann Dally and Peter Tarnesby of 1983-88 provide a window onto the middle period when the GMC and Home Office were both bringing disciplinary cases, sometimes against the same individual. Dally's cases in particular formed a turning point in the fortunes of private prescribers in England and a focus for the issues at stake.

The Ann Dally GMC Cases

Career prior to the first GMC case (1983)

Forceful, self-assured and articulate, Dr Ann Dally was the Oxford educated private doctor who started up AIDA in 1981 and became its first and only president. The 'Independent' in 'AIDA' referred to both private doctors and NHS doctors working outside the Clinics.⁵⁰ Although claiming to seek closer cooperation with the Clinics it was directly oppositional in both membership and activities (see Chapter 8) and several AIDA documents opened with attacks on the Clinics.⁵¹

Since the 1960s Dally had been working in private general psychiatric practice (although not formally qualified as a psychiatrist) in partnership with her husband (and later, ex-husband),

⁴⁹ Home Office Inspector, (2002) *op. cit.*

⁵⁰ AIDA, 'Management of Addiction', [flier announcing formation of AIDA], (November 1981), File PP/DAL/B/4/1/1/2, Wellcome Library, London.

⁵¹ eg AIDA, 'Drug Addiction: Guidelines and Standards in Management', Pre-publication edition. (February 1982). File PP/DAL/B/4/1/1/5, Wellcome Library, London.

psychiatrist Peter Dally. By 1979 she was already known as a writer on medical matters and a respectable doctor when she started treating opiate addicts in quantity. She developed her philosophy that they were victims of the system of drug controls, forced into a criminal lifestyle to obtain their supplies, attributing most adverse health effects to the illegal market rather than to the drugs themselves.⁵² Although she declared that AIDA members did not use the word "maintenance" because it suggested a category of "hopelessness", she believed that long term prescribing would allow addicts who were unable to achieve abstinence to live healthy, productive, law-abiding lives.⁵³ In the 1980s Ann Dally was the subject of two GMC cases, the second of which was resumed a year and a half later to check her compliance with imposed conditions.

AIDA's first meetings took place at the Home Office with Bing Spear, Home Office Drugs Branch Chief Inspector, attending.^{54,55} He and Dr Dorothy Black, Senior Medical Officer at the Department of Health and Social Security (DHSS), provided comments and contributions to the Association's draft clinical guidelines.⁵⁶ They were careful, however, to make clear that they were not present as 'observers', as they had been described in the AIDA minutes,⁵⁷ and that such status only applied at major external meetings. Furthermore, Dorothy Black was at pains not to 'take sides' in the dispute between doctors outside and inside the Clinics. In her response to AIDA's draft guidelines,⁵⁸ she disapproved of the document's criticism of the Clinics, chiding its authors, 'A responsible body such as your own should stand on your own practice rather than on a comparative exercise with that of others'.⁵⁹ So while civil servants concerned with drug policy were scrupulous in maintaining public distance and impartiality, Dr Dally was accepted and encouraged inside one part of the policy community as the respectable face of private practice.

Part of Ann Dally's intention in setting up AIDA was to raise standards among private doctors to which the clinical guidelines were to contribute. In the early 1980s there was great concern over drug users taking *Dionnal* (the opiate dipipanone combined with the anti-nausea drug cyclizine) particularly as some were crushing up the oral tablets and injecting them with disastrous

⁵² A. Dally, (1990) *op. cit.*, pp.87-98.

⁵³ A. Dally, Letter to N. P. Da Silva, (27th February 1984), File PP/DAL/B/4/1/1/1, Wellcome Library, London.

⁵⁴ AIDA, Minutes of Meeting held at the Home Office on 29th July, 1982, File PP/DAL/B/4/1/1/4, Wellcome Library, London.

⁵⁵ GMC, Professional Conduct Committee, Day Two, (6th July 1983), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.2/53.

⁵⁶ AIDA, 'Drug Addiction: Guidelines and Standards in Management', Pre-publication edition, (February 1982). File PP/DAL/B/4/1/1/5, Wellcome Library, London.

⁵⁷ D. Black, Letter to A. Dally, (19th March 1982), File PP/DAL/B/4/1/1/5, Wellcome Library, London.

⁵⁸ AIDA, 'Drug Addiction: Guidelines and Standards in Management', Pre-publication edition, (February 1982), File PP/DAL/B/4/1/1/5, Wellcome Library, London.

⁵⁹ D. Black, Letter to A. Dally, (19th March 1982), File PP/DAL/B/4/1/1/5, Wellcome Library, London.

consequences. They were often obtained from doctors unaware of or indifferent to the uses to which they were being put. In September 1982 AIDA resolved that 'the use of *Dional*, except in the most exceptional circumstances, is incompatible with membership of our Association',⁶¹ a declaration that was to trip up Dr Dally later on.⁶¹ AIDA also agreed that Dr Dally should write to Dr Rai, a member of AIDA, to expel him from the Association for prescribing *Dional*, which she did.^{62,63} Rai was then disciplined by the GMC in 1984.

Ann Dally and Margaret Thatcher were contemporaries at Somerville College, Oxford. In 1983 before the GMC initiated their case against her, Ann Dally visited Mrs Thatcher at 10 Downing Street, to express her views on drugs policy and treatment. Dr Dally was highly critical of the Clinics at this meeting, which was also attended by Dr Pamela Mason, a senior doctor in the Drugs Section of the DHSS.⁶⁴ As a good networker, Dr Dally was successful in achieving access to policy circles, but with little direct influence. Although impressed by her sincerity, Mrs Thatcher did not take sides, and after the GMC's verdict in her first case, the Prime Minister wrote a reply to a letter from Dr Dally maintaining this line: 'I hope you will forgive me if I do not say anything about the circumstances of your case. But I know that this must be a painful situation for both you and your husband. I know too that the strength you have always shown will carry you through this difficult time.'⁶⁵

Opposition before the first GMC case

In the three years preceding Ann Dally's first case, it was clear that a period of largely peaceful co-existence between the Clinics and the private prescribers had ceased and hostilities were polarising the field. Attacks came from both sides, through official channels such as the ACMD and in the media. Articles critical of individual doctors in the tabloid press, had appeared years earlier, with for instance, the *Daily Mail* and *The Sun* pursuing Dr John Petro in 1967.⁶⁶ However, it was not until 1980 that the first attack on private prescribers, by Thomas Bewley, appeared in the medical press. Dr Bewley was one of the country's most senior Clinic psychiatrists and worked at London's St Thomas's and Tooting Bec IDUs. He recommended a list of safeguards to doctors, with special

⁶⁰ AIDA, 'Comments on: Department of Health and Social Security: Treatment and Rehabilitation (HMSO, 1982). Report of the ACMD', (January 1983), File PP/DAL/B/4/1/1/7, Wellcome Library, London, p.7.

⁶¹ GMC Professional Conduct Committee, Day Two, (6 July 1983), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London., p.2/12.

⁶² AIDA, 'Meeting, Home Office, 16.9.82' [handwritten notes], File PP/DAL/B/4/1/1/4, Wellcome Library, London.

⁶³ A. Dally, Letter to Dr D. D. P. Rai, (17th January 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

⁶⁴ A. Dally, *A Doctor's Story* (London: Macmillan, 1990).

⁶⁵ M. Thatcher, Letter to A. Dally, (11th August 1983), File PP/DAL/B/5/1/1, Wellcome Library, London.

⁶⁶ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.216.

precautions for and about private prescribers. In order to stop 'script doctors' Bewley suggested restricting all psychoactive prescribing to 'licensed practitioners only', of whom he was one,⁶⁷ which would have effectively stopped such prescribing outside the Clinics.

The debate was revisited in *The Lancet* in January 1982, which said, of private doctors prescribing opioids, 'Their rationalisation is that the patient is thereby "saved" from the black market; however, since most addicts can only finance their private consultation by selling parts of their prescription, knowingly or (with a stretch of the imagination) unknowingly the doctor is prescribing sufficient drugs for this purpose.'⁶⁸

Published later in 1982, the ACMD's *Treatment and Rehabilitation* report⁶⁹ included a strong attack on private prescribers and recommended a range of controls to regulate them. These included preparation of good practice guidelines that could be used in regulatory procedures and the strengthening of controls around the prescription of *Diconal*. The most senior doctor on the working group responsible for *Treatment and Rehabilitation* was Dr Thomas Bewley (see Chapter 3).

The Lancet returned to the subject in March and April 1983, with Hamid Ghodse, a junior psychiatric colleague of Dr Bewley, defending the Clinics and attacking doctors outside.⁷⁰ This prompted Dr Dally to write forcefully to contradict him.⁷¹ Bewley and Ghodse then teamed up together in what was perhaps the most significant attack in a medical journal, due to its use of 'evidence', uncompromising title and timing, the 'Unacceptable face of private practice: prescription of controlled drugs to addicts'.⁷²

This uninhibited assault on private prescribing was published in the *British Medical Journal* only three weeks before Dr Dally's first GMC case. Dr Bewley has said that it was written before Dr Dally's case came to light, and that he was unaware of the timing. It was accepted for publication on 8th April 1983, before Dally's first GMC hearing, and prior to the Preliminary Proceedings Committee's decision on 12th May 1983 to take the case to a disciplinary hearing.⁷³ However, Dr Bewley did concede that the questionnaire was 'not a piece of serious scientific research' but had

⁶⁷ T. H. Bewley, 'Prescribing psychoactive drugs to addicts', *British Medical Journal*, 281 (1980), 497-498, p.497.

⁶⁸ *The Lancet*, 'Drug addiction: British System failing', *The Lancet*, 1 (1982) 83-84, p.83.

⁶⁹ ACMD, *Treatment and Rehabilitation*, DHSS, (London: HMSO, 1982).

⁷⁰ A. H. Ghodse, 'Treatment of drug addiction in London', *The Lancet*, 1 (1983), 636-639.

⁷¹ A. Dally, 'Drug clinics today', *The Lancet*, 1 (1983), 826.

⁷² T. Bewley and A. H. Ghodse, 'Unacceptable face of private practice: prescription of controlled drugs to addicts' *British Medical Journal*, 286 (1983), 1876-1877.

⁷³ *Ibid.*

just been carried out to make a point.⁷⁴ The journal clearly wished to stir up controversy around private prescribing, featuring it, like Bewley's previous article, under the banner 'For Debate' and adding its own unsigned leader 'Doctors for drug addicts' which criticised both sides.⁷⁵

The questionnaire on which the article was based was methodologically weak, both in construction and the response rate of 69%, which Bewley himself later described as 'completely useless'.⁷⁶ One question asked drug users attending two NHS Clinics about the reasons why drug users attended private practitioners, but only half of the respondents had attended a private practitioner. Despite this, responses from all respondents were counted as valid, so that NHS patients were being asked to speculate as to the reasons for attending a private practitioner, including leading questions such as whether such doctors were 'more easily conned than clinic doctors'.

The article claimed that data from the Home Office Addicts Index showed a change in the previous three years so that a 'large numbers of addicts' were having drugs prescribed for them by private general practitioners. In fact, it was not possible to distinguish from the Home Office data used in the article whether the general practitioners were NHS or private. No quantitative data was collated for the research regarding the numbers of patients attending private practitioners or private prescriptions issued.

The article also claimed that the reason for 'such large numbers of addicts attending private practitioners' was that they prescribed *Diconal* and *Ritalin*, the two drugs at the centre of Ann Dally's trial. It blamed 'uncontrolled prescribing by private practitioners' in the 1960s for 'a severe spread of addiction', despite the fact that only one of the doctors considered the source of this in the 1965 Second Brain Committee report was working privately (see Chapter 2).^{77, 78} The article asked 'whether it was ever desirable to prescribe controlled drugs to an addict when a fee is paid'.⁷⁹ Bewley and Ghodse described 'an urgent need to control prescribing' of methadone, *Diconal* and *Ritalin*, either through the General Medical Council, the Home Office Tribunal system, or an extension of the licensing system to include all controlled drugs. Bing Spear described the article as

⁷⁴ T. Bewley, Interview by Sarah Mars, (2001).

⁷⁵ *British Medical Journal*, 'Doctors for drug addicts', *British Medical Journal*, 286 (1983), 1844.

⁷⁶ T. Bewley, (2001) *op. cit.*

⁷⁷ Interdepartmental Committee on Drug Addiction. *The Second Report of the Interdepartmental Committee* (London: HMSO, 1965) p.6.

⁷⁸ H. B. Spear, 'The early years of the "British System" in practice', in J. Strang and M. Gossop (eds) *Heroin Addiction And Drug Policy: The British System*. (Oxford; New York; Tokyo: Oxford University Press, 1994) pp.3-28.

⁷⁹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.145.

⁸⁰ T. Bewley and A. H. Ghodse, (1983) *op. cit.*, p.1877.

'an authoritative establishment attack on the private sector' that 'presented a wholly false picture of the conditions prevailing in the generality of [Clinics]'.⁸¹

The *BMJ*'s leader article in the same issue accused some private doctors of effectively selling drugs to addicts, who in turn funded their treatment by re-selling some of their prescriptions on the black market, but it did not spare the Clinics, which 'seem to have faded into decline'. It questioned their move to oral methadone, and called for 'new policy objectives' to contain the 'epidemic of drug use'.⁸²

As intended, debate was unleashed and eight letters appeared in subsequent editions of the journal, both critical and supportive of the article, from across the spectrum of the drug treatment community, including a (private) patient which was unusual for the policy debate at this time. The only current London Clinic psychiatrist among them, Pamela Aylett, supported the article and its call for an extension of the licensing system, standing firm with her London colleagues.⁸³ A former London Clinic psychiatrist, James Willis, who had stood out against the move away from heroin prescribing,⁸⁴ and a provincial psychiatrist, Dr G Milner, practising at Worcester Royal Infirmary, both had criticisms. Although Willis thought the private prescription of maintenance drugs 'out of the question', he saw the Clinics as hypocritical and moralising in their repudiation of heroin prescribing.⁸⁵ Dr Milner pointed up the London-centric view of the authors, blaming the spread of addiction in Worcestershire on NHS general practitioners. (Private prescribing was almost unknown outside the South East). He proposed that a single consultant psychiatrist should act as local co-ordinator of a district's treatment and also supported the ACMD's recommendation for district drug problem teams to support GPs.^{86,87}

Two private psychiatrists linked to Ann Dally both pointed to the methodology as flawed and condemned Clinic practices. Peter Dally, her ex-husband and contemporary practice partner, was a private and NHS general psychiatrist but did not treat drug dependence.⁸⁸ Dale Beckett had run a DDU in the late 1960s and early 1970s and then left for private practice. Dr Beckett was

⁸¹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.287.

⁸² *British Medical Journal*, 'Doctors for drug addicts', *British Medical Journal*, 286, (1983) 1844.

⁸³ P. Aylett, 'Prescription of controlled drugs to addicts' [letter], *British Medical Journal*, 287 (1983), 127.

⁸⁴ J. Willis, Interview by Sarah Mars (2003).

⁸⁵ *Ibid.*

⁸⁶ G. Milner, 'Prescription of controlled drugs to addicts' [letter], *British Medical Journal*, 287 (1983), 127.

⁸⁷ ACMD, (1982) *op. cit.*, p.83.

⁸⁸ P. Dally, 'Unacceptable face of private practice: prescription of controlled drugs to addicts', [letter], *British Medical Journal*, 287 (1983), 500.

particularly stung by the article's estimate of a private prescriber's annual incomes at £100,000, and called for better communication between the two sides to overcome such misconceptions.⁸⁹

At such a distance it has proven difficult to determine whether these responses were orchestrated by either side but correspondence from Dr Beckett, a fellow member of AIDA, to Dr Dally regarding his letter, suggested that she was at least aware it was being written, and it seemed highly unlikely that this was not also the case with the letter from Peter Dally.⁹⁰

Ellis Stungo, who had been a prescribing Harley Street psychiatrist since the 1950s, and Honorary Secretary of the Society for the Study of Addiction (1958-64),⁹¹ perhaps surprisingly, proposed an extension of the Clinic system and a highly controlled role for GPs with no place at all for private prescribers.⁹² In addition to the medical voices were two researchers, an occupational group that contributed increasingly to drug policy debates in the 1980s and '90s. They agreed with some of Bewley and Ghodse's points about injudicious and excessive private prescribing, but also pointed to shortcomings in the Clinics. Standing perhaps further outside the debate than the prescribing doctors, they used research evidence to argue that prescription controls were irrelevant to stemming the spread of opiate use because of the huge growth in the availability of trafficked heroin.⁹³ Finally the private patient, who was also a journalist, put many of the arguments also used by Ann Dally and AIDA: that the Clinics were unnecessarily rigid, treated all patients as if identical and prescribed too little. His own experience was that long term prescribing allowed him to hold down a job and maintain a 'reasonably normal life'.⁹⁴

Aside from comments on the article's methodology, this array of responses covered most of the points which were to constitute the public/private debate over the 1980s and '90s: the impact of prescribing on the incidence of addiction; centralisation versus decentralisation of prescribing decisions; the sources of fees paid by patients; leakage from prescriptions to other users; the potential incomes of private prescribers; the role of the black market in trafficked drugs and the healthcare worker-patient relationship.

⁸⁹ H. D. Beckett, 'Prescription of controlled drugs to addicts' [letter], *British Medical Journal*, 287 (1983), 127.

⁹⁰ H. D. Beckett, Letter to A. Dally, (17th June 1983), Wellcome Library File PP/DAI./B/4/2/1.

⁹¹ V. Berridge, 'The 1940's and 1950's: the rapprochement of psychology and biochemistry', 'The Society for the Study of Addiction 1884-1988', *British Journal of Addiction*, Special Issue, 85(8) (1990) 1037-1052.

⁹² E. Stungo, 'Prescription of controlled drugs to addicts' [letter], *British Medical Journal*, 287 (1983), 126-7.

⁹³ R. Hartnoll and R. Lewis, 'Unacceptable face of private practice: prescription of controlled drugs to addicts', [letter], *British Medical Journal*, 287 (1983), 500.

⁹⁴ A. B. Robertson, 'Prescription of controlled drugs to addicts' [letter], *British Medical Journal*, 287 (1983), 126.

In addition to these printed words, Dr Dally claimed that AIDA's Home Office meetings were forced to move to her home/practice premises in Devonshire Place after the Inspectorate was pressurised by Clinic psychiatrists Dr Thomas Bewley and Dr Philip Connell⁹⁵ as, 'Meetings there had given us a respectability that was unacceptable in some quarters.'⁹⁶ 'This coercion has been difficult to confirm, but Spear commented that, 'it was quite obvious the London consultants did not take too kindly to the contact the Drugs Inspectorate had with AIDA'.⁹⁷ Were Dr Dally's GMC cases, then, part of this medico-political battle, or was her claim of political motives an excuse from a doctor whose care had fallen below more widely accepted professional standards of the time?

The First Case Against Ann Dally (5th-7th July 1983)

Dr Dally was charged as follows:

'That, being registered under the Medical Acts, between 11th June, 1981, or earlier, and about 25th November, 1981, you abused your position as a medical practitioner by issuing to Brian Sigsworth a number of prescriptions for dipipanone hydrochloride with cyclizine [*Diconal*] and methylphenidate [*Ritalin*] otherwise than in the course of bona fide treatment, including the prescriptions listed in the schedule which was sent to you with the Council's letter of 20th April, 1983. And that in relation to the facts alleged you have been guilty of serious professional misconduct.'⁹⁸

At the end of the hearing, the PCC took the view that Ann Dally had disregarded her special responsibilities as a doctor by prescribing drugs of addiction and dependence in large quantities; having taken insufficient steps to establish that there were adequate therapeutic reasons for doing so and for failing adequately to monitor the patient's progress and the use to which the drugs were being put. She was judged guilty of serious professional misconduct and admonished. Because Ann Dally was not suspended or erased from the register, she was unable to appeal against the verdict.

This case concerned in particular the prescription of the oral tablet *Diconal*, the injected use of which had been the subject of so much concern in the preceding years. It was clear, however, that Dally's patient was not injecting the drug and the Council failed to trace back to Dr Dally the

⁹⁵ A. Dally, Interview by Sarah Mars, (2002).

⁹⁶ A. Dally, (1990) *op. cit.*, p.100.

⁹⁷ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.287.

⁹⁸ GMC, Professional Conduct Committee, Day One, (5th July 1983), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.1.

Dional he had sold. In 1981, when Ann Dally's prescribing occurred, there were no official guidelines on the treatment of addiction, no legal rules on specific matters such as dose, and the guidance given by the British National Formulary on *Dional* related only to the treatment of pain and terminal disease.⁹⁹ Ann Dally was also criticised for not taking urine tests to check on her patient's consumption of the prescribed *Dional*. Her defence argued that such tests were easily falsified by patients.

Critically, and in an apparent extension of the GMC's definition of a doctor's duty, Dr Dally was considered responsible for the fate of drugs prescribed. She had only prescribed *Dional* to five patients,¹⁰⁰ and had discussed the dose she was going to prescribe with a Home Office drugs inspector, Mr Heaton, although he was not medically qualified and the decision remained her responsibility.¹⁰¹ The question of serious professional misconduct therefore seemed to turn upon the extent to which a doctor could be held responsible for the drugs she prescribed and to what extent she could be expected to predict their diversion from the patient to another person.

The Second Case against Ann Dally (1986-1988)

Not long after the first case, Dr Dally felt apprehensive that a second was brewing. She had received a visit from two Home Office Inspectors who warned her that the Clinic doctors or 'drug dependency establishment' were trying to get a Tribunal brought against her.^{102,103} In June 1984 she wrote a letter to Margaret Thatcher, ostensibly about deficiencies in DHSS policy, writing, 'I believe my views are shared by an increasing number of interested and informed people. Perhaps partly because of this I have aroused much hostility in powerful circles. I believe that I am again in danger of being "fixed" as happened last year.'¹⁰⁴ Mrs Thatcher was sympathetic in her reply but did not refer to the GMC issues and again refused to take sides in the dispute.¹⁰⁵

As Dr Dally predicted, a few months later, Dr Bewley made a complaint against her to the GMC after she had taken on two of his former patients. However, on this occasion the GMC decided

⁹⁹ *Ibid.* p.40.

¹⁰⁰ GMC, Professional Conduct Committee, Day Two, (6th July 1983), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.2/30.

¹⁰¹ *Ibid.* pp.2/62-2/63.

¹⁰² A. Dally, (1990) *op. cit.*, p.134.

¹⁰³ Home Office Inspector, (2002) *op. cit.*

¹⁰⁴ Dally, A. Letter to M. Thatcher, (1st June 1984), File PP/DAL/B/4/1/1/1 (File 2 of 2), Wellcome Library, London.

¹⁰⁵ M. Thatcher, Letter to A. Dally, (7th June 1984), File PP/DAL/B/4/1/1/1 (File 2 of 2), Wellcome Library, London.

not to pursue the complaint. Early the following year a complaint by two of Dr Dally's patients against Dr Bewley was also disregarded by the GMC.

Perhaps reflecting a general scepticism over the seriousness of the first case, its ruling does not seem to have damaged Dr Dally's standing as in 1984 the Department of Health and Social Security invited her onto the Medical Working Group charged with producing good practice guidelines.¹⁰⁶ The working group included representatives from all the main relevant medical bodies, including two from AIDA (Ann Dally and Dale Beckett). However, AIDA made little headway on the working group, and the opposition Dally and Beckett expressed to the treatment modalities recommended by the *Guidelines* was not reflected in the final document. Although Dally, Beckett and some other dissenters considered writing a minority report, the Chairman and secretariat introduced a new committee procedure to prevent them breaking the appearance of consensus (see Chapter 4).^{107,108} Ironically the idea for the guidelines may have originated with AIDA, whose own guidelines were circulated to the Treatment and Rehabilitation Working Group during its final deliberations.¹⁰⁹

The *Guidelines* played a role in the second case,¹¹⁰ but were quoted by both Counsels in their arguments. The prosecution referred extensively to their warnings against long term prescribing, particularly of opioids, without specialist collaboration (ie from the Clinics).¹¹¹ But when a consultant psychiatrist from a DDU in Brighton gave evidence for the Council, Dr Dally's defence compared his Clinic's prescribing and showed that some of his patients received maintenance prescriptions against the *Guidelines'* advice.¹¹²

Donald McIntosh, a senior inspector from the Home Office, during an interview with Dr Dally, questioned whether she agreed with the *Guidelines*, but he also conceded under cross-examination at

¹⁰⁶ Medical Working Group on Drug Dependence, *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse*, DISS (London: HMSO, 1984).

¹⁰⁷ A. Dally, (1990) *op. cit.*, pp.127-132.

¹⁰⁸ A. Thorley, Interview by Sarah Mars, (2002).

¹⁰⁹ AIDA, TRWG(82)10, 'Drug Addiction: Guidelines and Standards in Management. Pre-publication edition, (February 1982), File DAC 7, DH Archive, Nelson, Lancashire.

¹¹⁰ A. Dally, (1990) *op. cit.*, p.196.

¹¹¹ GMC, Professional Conduct Committee, Day One, (9th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.1/12.

¹¹² GMC, Professional Conduct Committee, Day Three, (11th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. pp.3/56.3/58.

her second hearing that a doctor favouring a different treatment regime would not necessarily be acting irresponsibly.¹¹³

After interviews, a report and some correspondence the Home Office took no action against Dr Dally but the GMC decided to use the evidence the Home Office Inspectors had gathered to put forward its own case. The reasons for this difference in approach were unclear, but the Inspectorate's decision may have been influenced by Bing Spear who generally supported Dally's work.^{114,115} While taking action against some of the prescribers he considered less responsible, Spear seems to have recommended Dr Dally to at least one patient.¹¹⁶ The GMC may have been influenced in the opposite direction by Philip Connell, one of the most senior London Clinic psychiatrists, an active Council member from 1979 representing the Royal College of Psychiatrists, and strong opponent of private prescribing.

In September 1986, the GMC accused her of professional misconduct for a second time on two charges:

- Between February 1985 and or earlier and August 1986, or later she had been guilty of irresponsibly prescribing numerous controlled drugs in return for fees and
- (a) Irresponsible prescribing in return for fees in relation to a particular patient, A (i) in that at the initial consultation in February, 1982, she had failed to conduct a conscientious and sufficient physical examination, (ii) had not adequately monitored his progress on each occasion when a further prescription had been issued, and (b) that in October, 1985, when she decided not to issue any further prescriptions, she had discharged him without making arrangements for him to receive on-going care and treatment from another doctor.

After a gruelling eight days of hearings, the case was decided in January 1987 finding Dr Dally guilty of serious professional misconduct in relation to the specific charge about Mr A but not in relation to the general allegation of irresponsible prescribing. She was suspended from prescribing controlled drugs for the treatment of addiction for 14 months. Her appeal against the verdict to the Privy Council was unsuccessful.¹¹⁷

¹¹³ GMC, Professional Conduct Committee, Day One, (9th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.1/59.

¹¹⁴ A. Dally, (1990) *op. cit.*, pp.145-149.

¹¹⁵ Home Office Inspector, (2002) *op. cit.*

¹¹⁶ GMC, Professional Conduct Committee, Day One, (9th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. pp.1/71-1/72.

¹¹⁷ Privy Council, Appeal No.7 of 1987, *Ann Gwendolen Dally v. The General Medical Council*, Judgment of the Lords of the Judicial Committee of the Privy Council, Delivered the 14th September 1987, pp.1-8.

The Council failed to prove the first general charge of irresponsible prescribing, and the appeal conceded that medical opinion was divided on the issue of long term prescribing of controlled drugs to addicts.¹¹⁸ In this Dally may have been assisted by the British policy responses to concern about HIV which strengthened the position of those advocating maintenance or long term prescribing, although the dominance of 'harm reduction' in treatment did not take hold until several years later (see Chapter 2). In the four individual cases the Home Office Inspectors highlighted in the first charge, they were unable to prove irresponsibility, but on the second charge she was found guilty of serious professional misconduct. The patient had admitted to selling methadone ampoules prescribed by Dr Dally and the police had also proven this.¹¹⁹¹²⁰ One of the accusations was that Dr Dally had failed to provide a referral after discharging him as a patient. However, the patient had turned up late and was afterwards abusive. Furthermore, the patient went to his GP two days later and got a referral to Hackney Hospital DDU, but decided not to take it up. To consider this 'serious professional misconduct' seemed harsh, particularly as her practice was exonerated of the general allegations in the first part of the charge.

At least one commentator has characterised Dr Dally's second trial as an inappropriate attempt by the GMC to adjudicate over different schools of thought of medical practice, namely long term versus short term prescribing, when agreement or even relatively stable opinion were lacking in the field.¹²¹ There was much discussion of the appropriateness of long term prescribing during the hearing, but the fact that Dr Dally was cleared of the general charge of irresponsible prescribing partly vindicated her approach. Although the second charge was proven, most of the issues in it were matters of fact. What was more questionable was whether they were serious enough to require a disciplinary hearing, and could reasonable be considered 'serious professional misconduct' by the standards of the day.

The Second Case Resumed (4th July 1988)

This followed on from Ann Dally's 14 month suspension from prescribing controlled drugs the previous year. The same charge as the Second Hearing was made and the Chairman of the PCC judged that Dr Dally had failed to comply with the condition that was imposed on her registration when she had last appeared before the Committee as she had prescribed substances which were controlled under the Misuse of Drugs Regulations 1985 and subsidiary regulations. These were

¹¹⁸ *Ibid.* pp.2-3.

¹¹⁹ GMC, Professional Conduct Committee, Day Two, (10th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.2/7.

¹²⁰ GMC, Professional Conduct Committee, Day One, (9th December, 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.1/48.

¹²¹ R. G. Smith, (1994) *op. cit.*, pp.70-77.

DF118s (which included dihydrocodeine), *Dalmane* (flurazepam), *Rohypnol* (flunitrazepam) and *Valium* (diazepam). However, no further penalties were imposed due to confusion over which drugs were covered by the term 'controlled' and the chairman concluded 'I have been asked to make it clear that the Committee regard the term "controlled drugs" in that condition as meaning all drugs which are specified in Schedules 1-5 of the Misuse of Drugs Regulations 1985.'¹²² She regained her full registration and ability to prescribe controlled drugs on 14th November 1988, but by then had retired from practice.

The conflicting nature of the advice given to Dr Dally by the GMC and various official sources as to which drugs were 'controlled' was attested by one of the Home Office inspectors involved.¹²³ The British National Formulary and similar prescribing handbooks only marked with a 'CD' denoting 'controlled drug' those in Schedules 1-3, which were also the only ones subject to requirements for prescriptions to be handwritten, leading one commentator to remark, 'This case demonstrates nicely the great care and precision which is required in imposing conditions, and the desirability of explaining precisely what is intended to the practitioner.'¹²⁴

Motives behind the cases

Ann Dally has argued that the drug dependency 'establishment' made up of psychiatrists working in the London Clinics led by Dr Philip Connell and Dr Thomas Bewley, were instrumental in the two GMC cases against her,¹²⁵ with the intention of silencing or discrediting a vocal critic. Dr Dally had been warned in April 1984 that the drug dependency establishment were 'still trying to make trouble' for her and were trying to have her charged before a Home Office Tribunal. According to Dally, and one of the Inspectors present, she was advised, 'You will be judged by the standards of the clinics and if found wanting you will be deprived of your right to prescribe controlled drugs. It will all depend on how much you conform to what the clinic doctors want.'^{126,127}

While it has been difficult to trace the behind-the-scenes activities and complaints that led to the GMC cases, there were some pieces of evidence that were suggestive. The first case seemed to support Dr Dally's argument of malicious intent towards her as it concerned a fairly trivial matter: a single patient to who had sold some *Diconal* which may or may not have been prescribed by Dr

¹²² GMC, Professional Conduct Committee, (4th July 1988), Case of Dally, Ann Gwendolen (Resumed case) T A Reed & Co. [transcript], GMC Archive, London. p.48.

¹²³ Home Office Inspector, (2002) *op. cit.*

¹²⁴ R. G. Smith, (1994) *op. cit.*, p.163.

¹²⁵ A. Dally, (1990) *op. cit.*, p.122.

¹²⁶ *Ibid.* p.134.

¹²⁷ Home Office Inspector, (2002) *op. cit.*

Dally. Although there was considerable concern at the time that *Diconal* was being injected with dangerous results,¹²⁸ it was clear from the case that the patient to whom Dr Dally had prescribed the *Diconal* did not inject it.

Home Office inspectors confirmed that extensive checks had been made by Dr Dally with the Home Office Drugs Branch regarding the patient at the centre of the first case when she agreed to take on his care.¹²⁹ She had obtained information about his criminal record, finding that he had no records for supplying controlled drugs, and discussed the dose of *Diconal* that she was intending to prescribe. It appeared that attempts to get Dr Dally taken to a Home Office Tribunal may have failed and a medical body, of which one of her critics, Dr Connell, was a member, was used instead. Favourable testimony was given by the Inspectorate about Dally, although Bing Spear did say that he did not remember so high a *Diconal* dosage as she had prescribed.¹³⁰

However, considering Dr Dally was aware that she was under scrutiny, she may not have helped herself in the subsequent years before the second case for which the evidence was a little stronger. This time the police did prove that Ann Dally's patient was supplying drugs she had prescribed, after marking ampoules dispensed to him. Although difficult to predict or prevent this, she did ignore evidence that at least one of her patients was unemployed and so considered by regulatory authorities at risk of selling on part of his prescription. She had also discharged a patient, albeit one who had been abusive towards her, without arranging any follow-on care and had carried out minimal examination of a patient before prescribing to him, although no harm had come to him.

Going against the 'conspiracy' interpretation was Don McIntosh, a senior Home Office inspector who acted in Spear's place during his frequent sickness absences in 1985. He was *not* part of the 'drug dependency establishment', but rather one of a range of voices within the Inspectorate. Coming from the Bradford Office in the North of England, where private prescribing was virtually unknown, he felt that different standards were being allowed in the South East in terms of the quantities and range of drugs prescribed to addicts. In 1984 or '85 on moving to the London office of the Inspectorate, he stepped up interviews of private doctors and in his report on Ann Dally recommended a Tribunal.¹³¹ However, Peter Spurgeon, Spear's immediate successor, has

¹²⁸ GMC, Professional Conduct Committee, Day Two, (6th July 1983), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. pp.2/55-2/56.

¹²⁹ GMC, Professional Conduct Committee, Day Two, (6th July 1983), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. pp.2/61-2/63.

¹³⁰ *Ibid.* p.2/53.

¹³¹ Home Office Inspector, (2002) *op. cit.*

suggested a contrary view that McIntosh may have been reflecting pressure from the Clinics that Spear had been able to resist.¹³²

Dr Dally has argued extensively that the GMC was unfair in its conduct of the cases against her, believing it showed favouritism to its own members, vindictiveness and inconsistency.¹³³ One of her points was supported by Dr Michael O'Donnell, a member of the GMC's PCC, who argued that the Committee members were allowing themselves exemption from their own ethical guidelines by letting information from patients' notes to be used without their permission (provided the patients were not named) in Dr Dally's second case, and he withdrew from the case in protest.¹³⁴

A memorandum submitted by the GMC to the House of Commons' Social Services Committee on 20th February 1985 suggested that the Council had taken its own line on appropriate treatment for drug users prior to these cases. It read:

*The Council has hitherto eschewed the promulgation of specific views on the correct regime of treatment for a particular condition: if the Council promulgated such views it would tend to inhibit advances in therapeutics. Nevertheless, disciplinary inquiries into cases of this kind have all too plainly demonstrated the special hazards of medical practice in the field of prescribing to addicts, particularly when a doctor is in practice on his own. 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 of 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.*¹³⁵

A clear injustice against Dr Dally could be seen in the PCC's final judgment delivered by the Chairman, who restricted Dr Dally's prescribing, in the light of her 'blatant failure to heed the warning conveyed' by her 'previous appearance before this Committee in 1983 in relation to similar matters', since part of the charge proven in the second case – the inadequate examination of her patient "Mr A" – occurred in 1982 before her first hearing.¹³⁶

¹³² P. Spurgeon, Interview by Sarah Mars, (2004).

¹³³ A. Dally, (1990) *op. cit.*, pp.99-276.

¹³⁴ M. O'Donnell, 'One man's burden', *British Medical Journal*, 294 (1987), 451.

¹³⁵ Memorandum from the General Medical Council, House of Commons Social Services Committee, *Fourth Report: Misuse of Drugs with Special Reference to the Treatment and Rehabilitation of Misusers of Hard Drugs*, Session 1984-85, (London: HMSO, 1985) p.67.

¹³⁶ D. Braham, "'Serious Professional Misconduct" in Relation to Private Treatment of Drug Dependence', *Lancet*, i, 1987, pp.340-341, p.341.

If Dr Dally's opponents wanted her GMC cases to make an example of poor practice among private prescribers, the weakness of the charges and evidence against her made her a bad choice. Dr Tamesby, whom the GMC erased from the medical register in 1984, would have made a much stronger case against private practice. He had prescribed *Diconal* to an injecting addict, had four patients die and, in some cases, provided additional prescriptions after death. If, as Dr Dally claimed, they wished to silence a vocal critic or drive her from the field, then the second GMC case was successful, but although this is probable, it is still unproven.

With the departure of Dr Dally from the scene, private prescribers lost their strongest representative, but in some senses, Dr Colin Brewer, founder of the Stapleford Centre, a private drug and alcohol clinic employing several doctors and other staff in London, inherited Dr Dally's mantle. He was a member of AIDA, and like Dr Dally saw prescribing as a broader political issue touching major social questions. He too wrote on medical matters in the press and saw addicts as victims of an overly restrictive regulatory system for controlling the availability of drugs. When Dr Dally ceased her practice after the second GMC case, he took on many of her patients, and ironically in 2004 he and his practice became the subject of the largest GMC disciplinary hearing of private doctors ever held.

Dr H. Peter Tamesby, Second Case, 1984

The story of the 1984 *Guidelines* (see Chapters 3 & 4) was one where a mechanism for maintaining and raising standards of care and identifying cases of poor practice was hijacked by one ideology to dominate another. Some of the same tendencies could be seen in the Dally cases, but was this the case for all the Council's discipline against private prescribers over this period? A detailed review of every case has not been within the scope of this study, but a contrasting case study of Dr Herman Peter Tamesby suggested that in its dealings with private doctors the Council also had a role in protecting patients from incompetent or negligent practitioners.

Dr Tamesby was highly qualified, with a doctorate in psychological medicine and extensive experience as a psychiatrist. He had trained at the Maudsley Hospital from 1951-53 at the same time as Dr Bewley, and at the respected Tavistock Centre (1952-59). He had been appointed consultant psychiatrist at the British Hospital for Functional Nervous Disorders and he had worked with some drug dependent patients as a consultant at Paddington Hospital although it was not clear whether this had involved any prescribing. Dr Tamesby then worked as a private

psychiatrist, with consulting rooms in and around Harley Street, with only a little contact with drug users until he started treating them in quantity from 1981.^{137,138}

The GMC charged him with prescribing both irresponsibly and otherwise than in the course of bona fide treatment in 1984. Since a Home Office Tribunal had already proved him guilty of irresponsible prescribing the previous year, he only contested the second part of the charge, that his prescribing was 'otherwise than in the course of bona fide treatment'.¹³⁹ His first brush with the GMC, it was revealed at the end of the 1984 hearing, had occurred in 1969 when he was found guilty of serious professional misconduct for advertising abortion services.¹⁴⁰

Although Dr Tamesby had a high level of professional qualifications and experience, and went to some lengths to research and refine his treatments for drug users, even commissioning the production of special methadone suppositories to avoid the need to prescribe injectables, he also seems to have made some serious errors of procedure and judgment.¹⁴¹ He prescribed drugs to a patient whom he had not examined thoroughly and turned out later to be an undercover reporter for the *Daily Mirror*, treated several patients who subsequently died of overdoses using drugs he had prescribed, and kept inadequate records.^{142,143,144}

There were a number of similarities with Dr Dally's cases, which have pointed up the difficult position drug doctors could be put in by the regulatory authorities, such as whether to discharge a patient who was not meeting their fees for fear that they could be selling some of their script. Also, the practice of the Clinics seems to have been taken as the ideal against which other treatment had to be measured, reflecting the stronger position of the Clinics within establishment bodies such as the GMC.^{145,146} But overall, the evidence did show a carelessness that turned out to have serious,

¹³⁷ Thomson Directories, Ltd, *London Classified Trades and Professions, Telephone Directory 1968* (London: General Post Office, 1968) p.940.

¹³⁸ GMC, Professional Conduct Committee, Day Four, (9th March 1984), Case of Tamesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. pp.16-18.

¹³⁹ GMC, Professional Conduct Committee, Day One, (6th March 1984), Case of Tamesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. unnumbered page, preceding p.1.

¹⁴⁰ GMC, Professional Conduct Committee, Day Five, (10th March 1984) Case of Tamesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. pp.88-90.

¹⁴¹ GMC, Professional Conduct Committee, Day Four, (9th March 1984), Case of Tamesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. pp.1-79.

¹⁴² *Ibid*, pp.11-12.

¹⁴³ GMC, Professional Conduct Committee, Day Five, (10th March 1984) Case of Tamesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. pp.17-22.

¹⁴⁴ GMC, Professional Conduct Committee, Day Two, (7th March 1984), Case of Tamesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. pp.33-35.

¹⁴⁵ GMC, Professional Conduct Committee, Day Four, (9th March 1984) Case of Tamesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. p.27.

even fatal consequences for his patients. However, considering the fact that he had already been stopped from prescribing substitute drugs by the Home Office, he probably posed no continuing threat to drug users.

Defining Terms

The lack of definitions of the GMC's code of practice regarding 'bona fide' and 'irresponsible prescribing', the latter term also undefined in its inclusion in the Misuse of Drugs Act 1971, had left much latitude to doctors' clinical judgment, but this freedom could also be a trap as it allowed regulators, whether the state or professional peers, equal scope to interpret these terms as they chose. Smith noted various attempts to clarify the meaning of 'bona fide' at GMC hearings, with it usually being left to the discretion of individual committee members.¹⁴⁷ Clarification could be brought by the Legal Assessor, a lawyer advising the PCC, as was the case with the final definition of 'bona fide' used in the first Dally case.¹⁴⁸

However, his definition did not quell concern among commentators. Diana Brahams, a barrister writing for the *Lancet* after Dally's admonition, considered 'disquieting' the way in which the charge of prescribing drugs 'otherwise than in the course of bona fide treatment' was interpreted by the PCC.¹⁴⁹ Brahams was concerned that the term was only defined as 'recklessness' at a late stage, but then this was found to be unsuitable. Definitions were then provided for 'bona fide' which seem to have amounted to recklessness, making the ruling inconsistent. If the term meant, in literal translation, 'good faith', Brahams further argued that the evidence against Dr Dally seemed 'to fall well short of proof of a lack of good faith'. Certainly considerable care seems to have been taken by Dr Dally to prevent the prescribed *Dional* from falling into unintended hands and Ms Brahams concluded her criticism of the GMC by calling for 'more positive guidelines and procedures...for the private management of drug dependence'.¹⁵⁰

In spite of the Legal Assessor's definition, confusion continued in subsequent cases. In the Tarnesby case, held in March 1984, the defence spent considerable time trying to define the charges, including the meaning of 'bona fide' noting that 'the charge uses words which are difficult to define and which the Committee may have had problems with on other occasions'. 'The Legal

¹⁴⁶ GMC, Professional Conduct Committee, Day Five, (10th March 1984) Case of Tarnesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. p.85.

¹⁴⁷ R. G. Smith, (1994) *op. cit.*, pp.39-40.

¹⁴⁸ GMC, Professional Conduct Committee, Day Two, (6th July 1983) Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. pp.2/82-2/83.

¹⁴⁹ D. Brahams, 'No right of appeal against GMC finding of serious professional misconduct without suspension or erasure', *The Lancet*, 2 (1983), 979-981, p.979.

¹⁵⁰ *Ibid.* p.980.

Assessor stepped in again, but not, as one might have expected, to refer back to the earlier ruling in the Dally case, but to state that no additional wording was required to clarify the term, only a simple English translation of 'good faith'.¹⁵¹

Dr Tarnesby's defence also had difficulty over whether reference to the quantity of drugs meant prescribed *overall* or *per patient*, over the time period covered by the charges; and the significance of 'prescribing in return for fees',¹⁵² a phrase also used in Dr Dally's first case. Since private doctors charged fees and provided prescriptions during the course of their consultations, it would seem difficult to distinguish clearly when a fee was being charged for a prescription and when for a consultation, possibly weighting the system against private prescribers.

Ambiguity arose yet again in the terms of Dr Dally's penalty in the second case, when forbidden 'to prescribe or possess controlled drugs', which were never made explicit, with clarification only given at the end of the period of suspension.¹⁵³

Although the GMC had failed to advise its members on how they should prescribe to drug users and avoid regulatory attention, after 1984, as a spokesperson explained to the House of Commons Social Services Committee in 1985, there were other sources of guidance. By the time of Dr Dally's second case, doctors working privately had, according to the GMC's prosecution, four key sources of written advice: the 1984 *Guidelines*, the passing reference in the GMC's 'Blue Book', and two articles by London Clinic psychiatrists in the *British Medical Journal*. However, none of these were based on research evidence and like Dr Dally's practice and beliefs, they were effectively the product of personal experience and opinion.^{154,155,156,157}

In the Tarnesby case the role of witnesses pointed up the problems around 'expertise' in this polarised, politicised field, and the potential conflict this could produce within a system of regulation based upon professional consensus. Dr Bewley, a vocal opponent of private prescribing,

¹⁵¹ GMC, Professional Conduct Committee, Day Five, (10th March 1984), Case of Tarnesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. p.87.

¹⁵² GMC, Professional Conduct Committee, Day Four, (9th March 1984), Case of Tarnesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. p.2-9.

¹⁵³ GMC, Professional Conduct Committee, (4th July 1988) Case of Dally, Ann Gwendolen (Resumed case) T A Reed & Co. [transcript], GMC Archive, London. p.48.

¹⁵⁴ Medical Working Group on Drug Dependence, *Guidelines of Good Practice in the Treatment of Drug Misuse*, (London: DHSS, 1984).

¹⁵⁵ GMC, *Professional Conduct and Discipline: Fitness to Practice*, edition 61. (London, GMC, 1985).

¹⁵⁶ T. H. Bewley, (1980) *op. cit.*, pp.497-498.

¹⁵⁷ P. H. Connell and M. Mitcheson, 'Necessary safeguards when prescribing opioid drugs to addicts: experience of drug dependence clinics in London', *British Medical Journal*, 288 (1984), 767-769.

was called as a witness for the Council. Dr Tarnesby had prescribed to one of Bewley's long-standing patients, causing Dr Bewley to write him a vigorous letter of complaint. A second patient of Bewley's who went to Dr Tarnesby for treatment died of a *Diconal* overdose and Bewley had given evidence against Tarnesby at his Home Office Tribunal the previous year. In spite of Dr Bewley's clearly opposing position, he was treated as a neutral 'expert' by the committee, who saved a question of pharmacology arising earlier in the proceedings for him to answer.¹⁵⁸

Uncertainty also characterised the nature of the GMC's disciplinary powers. It had the legal powers of a tribunal, and required the level of proof to be the same as a criminal court, 'beyond reasonable doubt', but the charges could be specific or like the first charge of 'irresponsible prescribing' in Ann Dally's second case, very general and unattached to any particular patient. The dates to which these charges applied could also float freely, a point picked up by Dr Tarnesby's defence; his charge was situated 'Between about 13 October 1981 or earlier and about 10 February 1983 or later...'¹⁵⁹

Reading the transcripts of these hearings one is given the impression that the committee members themselves were unsure of their roles, perhaps unsurprising in view of the minimal preparation they were given.¹⁶⁰ Legal counsels too might be inexperienced in the ways of the GMC: Dr Tarnesby's defence was unused to the niceties of medical confidentiality and repeatedly revealed the identities of patients through the proceedings.

The Media

The media acted as both a conduit for the views of either side of the debate and as an actor in its own right. There was an important contrast in the way that Ann Dally and the London consultants used the media, which may have had implications for the actions taken against her. The consultants published articles and letters in the medical media,¹⁶¹ but very rarely took the debate to a general audience through press, television or radio. Already an established medical commentator, Ann Dally was outspoken and particularly prolific, and in the 1980s began to write many letters to the general press and appeared on the radio and television.

Stimson and Lart have identified the style of policy making visible in the drugs field in the 1960s and the 1970s as carried out behind the scenes in 'an essentially private world where policy was

¹⁵⁸ GMC, Professional Conduct Committee, Day Three, (8th March 1984), Case of Tarnesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. p.54.

¹⁵⁹ GMC, Professional Conduct Committee, Day One, Tuesday 6th March 1984, Case of Tarnesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. p.1/1.

¹⁶⁰ See M. Stacey, (1992) *op. cit.*, p.141.

¹⁶¹ eg. J. Strang, 'Personal View', *British Medical Journal*, 284 (1982), 972.

made by accommodation between experts and civil servants'. The ACMD, established in 1971, continued in this tradition¹⁶² and its discussions were subject to the Official Secrets Act.

In the 1970s, policy changes among the London consultants, such as the switch from heroin to methadone prescribing, took place through committees (the London Consultants Group, discussed in Chapter 8) which met in private and in discussions at medical conferences, rarely involving public campaigns, and almost never involving patient participation. Treatment policies were seen as largely a private affair, and it is the conclusion of this research that it was the public nature of Ann Dally's attacks on the Clinics that so embittered the London consultants as much as the content of the attacks themselves. Raising in public what the London consultants saw as matters for private discussion broke their code of discreet, private policy-making, and involved the public and patients in the issues.

On a rare occasion, Dr Philip Connell, other London Clinic consultants, and some representatives of voluntary services wrote to *The Times* proposing that all prescribing doctors should be supervised by the Clinics.¹⁶³ In response, Ann Dally wrote to the editor one of her earliest expressions in the media on this topic:

*Recently I questioned 30 heroin addicts who were seeking treatment. All but one said that under no circumstances would they go (or, in some cases, return) to a detoxification unit... What they object to is the way these units are run. These patients have much the same feelings about out-patient Drug Dependence Units or 'clinics' whose authority Dr Connell now wishes to extend over doctors outside. Nearly all my addict patients have at some time attended such a clinic. All are critical.*¹⁶⁴

While Dr Dally continued to raise these questions with the ordinary public, her key opponents, Drs Connell and Bewley, rarely did so, restricting their opinions to medical fora, such as the *British Medical Journal* and *The Lancet*.

In response to Dally's letter to *The Times*, she received one from William Deedes, editor of the *Daily Telegraph*, congratulating her, but in the early 1980s, journalists in the general press, and particularly

¹⁶² G. V. Stimson and R. Lart, 'The Relationship Between the State and Local Practice in the Development of National Policy on Drugs between 1920 and 1990', in J. Strang and M. Gossop (eds), *Heroin Addiction And Drug Policy: The British System* (Oxford, New York, Tokyo, Oxford University Press, 1994), pp.331-341, p.336.

¹⁶³ M. Ashton, Conference (almost) agrees on central funding, licensed GPs, more detoxification', *Druglink Information Letter*, 15 (1981), 6.

¹⁶⁴ A. Dally, 'National resources for drug abuse', Letter to *The Times*, (27th January 1981), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

the tabloids, were often hostile.¹⁶⁵ Although widely featured in the media, Dally often felt misrepresented.¹⁶⁶

As well as the medical press and general media criticising both the Clinics and private doctors,^{167,168,169,170} the tabloid press took a more active approach using undercover reporters to pose as drug dependent patients to test the ease with which they could obtain prescriptions from private prescribers, continuing these sting operations into the 1990s. In the case of Dr Tarnesby the resulting article in the *Daily Mirror* prompted investigations by the Home Office Drugs Inspectorate and were also heavily featured in disciplinary cases before the GMC.^{171,172,173,174}

The article by Bewley and Ghodse and the correspondence that followed was provided as background material to the medical working group responsible for producing the 1984 *Guidelines*,¹⁷⁵ which played a role in Ann Dally's second case. Around this time Dr Dally was also participating in a Thames Television programme 'Reporting London' on the prescription of *Diconal*.¹⁷⁶ So here, private was 'public' and public was 'private'.

Following the verdict of the first case, Dr Dally received sympathetic letters and coverage from Elinor Harbridge of *World Medicine*, Ian Monro and Diana Brahm of the *Lancet* and also Penny Chorlton of *The Guardian*, who wrote 'I do feel you were made a scapegoat for challenging the establishment's approach [sic] to drug addiction.'^{177,178,179,180} Michael O'Donnell, a member of the GMC, also wrote in the *British Medical Journal* against the verdict.¹⁸¹

¹⁶⁵ eg J. Ritchie, 'Drug crazy Britain', *The Sun*, London, (17th December 1980), 14-15.

¹⁶⁶ A. Dally, Letter to M. Bishop, (5th July 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

¹⁶⁷ eg, *The Lancet*, 'Drug dependence in Britain: a critical time', *The Lancet*, 2 (1983), 493-494.

¹⁶⁸ eg, *The Lancet*, 'Drug addiction: British System failing', *The Lancet*, 1 (1982), 83-84.

¹⁶⁹ eg M. Honigsbaum, 'The addiction arguments that divide the doctors', *Hampstead and Highgate Express*, (6th May 1983), 2.

¹⁷⁰ eg, Anonymous, 'Doctor Death', *The Listener* (29th July 1982), 22.

¹⁷¹ See J. Merritt, 'Doctors who trade in misery', *Daily Mirror*, (18th February 1982), 7-8.

¹⁷² GMC, Professional Conduct Committee, Day Three, (8th March 1984), Case of Tarnesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. pp.39-85.

¹⁷³ GMC, Professional Conduct Committee, Day Four, (9th March 1984) Case of Tarnesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. pp.11-12; 34-39.

¹⁷⁴ GMC, Professional Conduct Committee, Day Five, (10th March 1984) Case of Tarnesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. pp.13-19; 48-51.

¹⁷⁵ Medical Working Group on Drug Dependence, *Guidelines of Good Practice in the Treatment of Drug Misuse*, (London: DHSS, 1984).

¹⁷⁶ A. Dally, Letter to S. Perrins, (7th March 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

¹⁷⁷ I. Munro, Letter to A. Dally, (day and month missing, 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

¹⁷⁸ P. Chorlton, Letter to A. Dally, (20th July 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

The second GMC case against Ann Dally aroused much more attention both from the public and in the medical world. At a time when the prevention of HIV/AIDS was becoming part of a public policy debate and the government had already started to sponsor needle exchange schemes, a great deal of discussion regarding appropriate prescribing appeared in the media, which was becoming more sympathetic towards long term prescribing.^{182,183,184,185} The prosecution feared that the publicity would 'turn the inquiry into a political debate.'¹⁸⁶ In the drugs field, Mike Ashton, editor of the Institute for the Study of Drug Dependence's *Druglink*, characterised the two Dally cases as political in origin: 'The powerful tide of medical opinion that wants prescribing more tightly controlled' was extending the GMC's powers from assessing treatment of the individual patient to the question of whether any drugs of dependence prescribed might be redistributed and harm other members of the public.^{187,188}

If they had wanted to silence her, the media attention that both Dr Dally's GMC cases drew rather backfired on her detractors. Press and public were able to sit in on the hearings and they and Dally drew the debate into the public realm, beyond the medical media, widening the debate beyond the drugs issues to include the GMC process itself as well as the justice of its decision.

Doctors not only had their own publications, which also had a standing outside of their professional circles, but also easy access to the non-medical media. Furthermore there was considerable public interest in medical issues throughout this period and as a medical professional, a writer or broadcaster held an automatic authority. For the tabloids, the shock value in undermining an apparently respectable figure by duping him in an undercover operation was all the greater. Since drugs were a particularly emotive topic, dividing the public as much as the profession, media coverage was ensured. All aspects of this output fed the public-private debate not only at the rhetorical level, but in its expression through regulatory action, whether by the Medical Working Group responsible for the 1984 *Guidelines*, the Inspectorate or the GMC itself.

¹⁷⁹ D. Brahm, (1983) *op. cit.*, pp.979-981.

¹⁸⁰ E. Harbridge, Letter to A. Dally, (14th July 1983), File PP/DAL/B/4/1/1/1 (file 1 of 2), Wellcome Library, London.

¹⁸¹ M. O'Donnell, 'One man's burden', *British Medical Journal*, 287 (1983), 990.

¹⁸² eg. M. Ashton, 'Doctors at war', *Druglink*, 1 (1986), 13-15.

¹⁸³ eg. J. Laurance and A. Dally, 'Racketeer or rescuer?', *New Society*, 1256 (1987), 18-19.

¹⁸⁴ eg. Anonymous, 'Heroin on the NHS', *New Society*, 1269 (1987), 3.

¹⁸⁵ eg. *Panorama*, BBC1 (1987).

¹⁸⁶ GMC, Professional Conduct Committee, Day One, (9th December, 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.1/21.

¹⁸⁷ M. Ashton, (1986), *op. cit.* 13-15, p.15

¹⁸⁸ M. Ashton, 'Doctors at War', *Druglink*, 1(2) (1986), 14-16.

Conclusion

The role of the GMC was problematic in the Dally cases for a number of reasons. A key plank in medicine's self-regulation was the idea of professional consensus, something clearly lacking in the drugs field during the 1980s, and to a slightly lesser extent in the adjoining decades. Added to this, the lack of guidance as to what could lead to disciplinary steps and even on the conditions imposed on prescribing after a verdict, created an unfair situation for doctors, and scope for redefining ambiguous terms to suit personal or professional animosities.

Ambiguity arose as a major theme of prescribing regulation in England regarding the jurisdiction of different regulatory bodies and in the guidance given to doctors about prescribing to drug users. Baker has traced back British medical ethics to a code of honour of the eighteenth and nineteenth centuries, where, by virtue of being a gentleman, a doctor was not deemed to require precise, codified guidance. Indeed the need for such explicit instruction on ethics and conduct could mark one out as unsuited to practising medicine.¹⁸⁹ Gentlemanly status, however, was something most doctors aspired to rather than achieved at this time. Particularly before the 1858 Medical Act and the establishment of the exclusive Medical Register, most ordinary doctors in England were of low social status.¹⁹⁰

After the Second World War the British medical profession developed a more codified set of medical ethics but resistance to explicit advice continued. The Morrison Inquiry rejected the idea of a code of practice to give doctors a better idea of what might lead to disciplinary actions in favour of building up 'case law' as had been done in the past.¹⁹¹ But 'case law' seems to have been used inconsistently, with rulings at one hearing not carried over to subsequent ones, and the same confusions arising repeatedly. The GMC's reluctance to be pinned down in giving guidance to its members could also be seen in the laggardliness of its Standards Committee to decide on whether to expand its advice on prescribing opioids.

The GMC's repeated reluctance to state definitively what constituted non-bona fide or irresponsible prescribing, the lack of guidance from either the British Medical Association or GMC on the treatment of drug users, and the uncertain meaning of the Misuse of Drugs Act term

¹⁸⁹ R. Baker, 'British and American Conceptions of Medical Ethics, 1847-1947', Anglo-American Medical Relations: Historical Insights Conference, 19th-21st June 2003, The Wellcome Building, London, UK.

¹⁹⁰ D. Porter and R. Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Stanford, CA: Stanford University Press, 1989).

¹⁹¹ M. Stacey, (1992) *op. cit.*, p.57.

'irresponsible prescribing' reflected both the profession's discomfort at judging the clinical decisions of other doctors and the uncertainty of the drugs field itself in the 1960s, 70s and early '80s.

Competing schools of thought with different treatment goals, the lack of a robust scientific evidence base, and a relatively low level of technical expertise required for treating drug users all made competence difficult to define. This vagueness, particularly when the GMC was increasingly being called to be specific during the 1980s, led to a situation exploitable by forces keen to restrict prescribing particularly over those in private practice.

The profession had a poor record of concern for regulating the treatment of patients, particularly when these patients were socio-economically disadvantaged.¹⁹² During the 1970s and '80s, the rise of patients' rights and consumerism outside of the profession increasingly pressurised the GMC to address issues of clinical decision making, especially when it involved neglect, harm or death caused by practitioners.¹⁹³ Stacey noticed a rise in disciplinary cases concerning doctors' conduct in the 1980s and '90s and the case of Dr Tarnesby showed that the GMC did fulfil some role in protecting drug-using patients from private prescribers whose practice was dangerous, however reluctantly.

Whether there was a conspiracy to remove Dr Dally as a thorn in the side of the drug dependency establishment has been difficult to prove for certain, but some of the evidence pointed in that direction. Bing Spear, although not impartial, seemed convinced this was the case. Her first case was brought on a slim pretext, and the procedure itself was flawed. The second case, though a little stronger, was still not damning, and she was doubly condemned for failing to heed the warning of the first, when some of its charges pre-dated it. Dr Dally was exonerated of the second case's general charge of irresponsible prescribing, which pointed against the idea that she was condemned for following a different 'school of thought'. Yet the fact that the minor misdemeanours proven in the second part of the charge were defined as 'serious professional misconduct' and brought suspension of her prescribing rights, has suggested a bias against her.

Although Dr Dally was effectively driven out of the prescribing field by the two GMC cases, the media attention from outside medicine that they brought to the debate and to the Council's treatment of her rebounded on her critics. If part of their irritation was her high profile as a critic

¹⁹² R. Cooter, (2000) *op. cit.*, pp.457-460.

¹⁹³ M. Stacey, (1992) *op. cit.*, pp.173; pp.181-199.

of the Clinics, the cases only brought her more publicity, and some of the sympathy she received from the media was at the expense of her opponents.

While much attention has been given to the question of whether Dr Dally was being judged by the standards of the Clinics, there was also the issue of how much the GMC had absorbed the interests of the state in the form of the Inspectorate. Dally and Tarnesby's cases have shown that the Inspectorate's responsibility to control the flow of prescribed drugs within authorised channels had effectively been incorporated into the body of medical ethics for professional self-regulation. In their practice, private doctors were expected to distinguish between patients likely to divert drugs, to prevent their prescribed drugs reaching the hands of others and to keep monitoring their employment status.

Although advised by the Inspectorate, doctors were responsible for their own prescribing decisions, and the priorities of the state in controlling the circulation of drugs would not necessarily concur with the therapeutic or practical needs of the patient, regarding which they were also answerable. Ethical decisions about whether to treat had to take into account the patient's ability to pay from legitimate sources of income. Here, private doctors' practice had developed a criminal policing role that was not imposed upon Clinic doctors, while leakage from the Clinics, admitted by the Inspectorate, was being overlooked.¹⁹⁴

The low level of technical skills and limited research on which knowledge could be based and measured against in the drugs field left those wishing to distinguish between the acceptable and unacceptable treatment of addiction in need of other criteria to maintain their authority. The co-opting of these criminal concerns by the GMC as part of its body of ethics in these cases perhaps reflected the need of Clinic elements within and around the Council for an alternative measure of competence as part of their professionalizing strategy.

The Dally and Tarnesby cases therefore arose as the focal points of a range of historical forces. Drug use, particularly of opiates, was rising dramatically in the 1980s, along with the number of doctors treating it, particularly outside the Clinics. In response to several forces of outside pressure, the GMC had begun to take greater notice of cases concerning doctors' clinical conduct, and more such cases were brought forward for disciplinary action during the 1980s. Its reluctance to act on such matters, and preference for each case to be judged by its members as it arose, was expressed in

¹⁹⁴ GMC, Professional Conduct Committee, Day One, (9th December 1986), Case of Dally, Ann Gwendolen, T. A. Reed & Co. [transcript], GMC Archive, London. p.1/47.

its distaste for giving specific guidance on appropriate prescribing. Together, these conditions offered a window of opportunity for those doctors who wished to cut through the fog of controversy and exert their authority as the arbiters of drug treatment. At the turn of the twenty-first century, even greater pressures upon the Council and the profession were similarly employed to devastating effect on private prescribers.

Chapter 6

The Role of the Home Office Drugs Inspectorate and the Misuse of Drugs Tribunals

Introduction

This chapter concerns permanent, formal regulatory systems dealing with the prescribing of controlled drugs. It focuses in particular on the Home Office Inspectorate ('the Inspectorate'), its relationships with other regulatory bodies with cross-cutting concerns and how these regulatory systems changed over the period. It reflects on their impact on the regulated, particularly the doctors treating drug users.

Very little has been published about the Inspectorate or these relationships. Historian Virginia Berridge has considered the social, legislative and policy changes that surrounded the development of these structures, but not the development of the Inspectorate itself.^{1,2} H. B. 'Bing' Spear, Chief Inspector at the Drugs Branch from 1977 to 1986, has written a rare historical account of its origins, placing them in 1916 when the Home Secretary authorised a temporary administrative assistant, A. J. Anderson, to inspect records of cocaine supplies which pharmacists had been required to keep from earlier the same year. However, the rest of his book on the 'British System' took a broader policy scope, leaving the Inspectorate's development somewhat on the sidelines.^{4,5}

The Tribunal system used by the Inspectorate to enforce the law against prescribers, has attracted some attention, with articles by sociologist Philip Bean and also by Spear, but were written before major developments in the 1990s.^{6,7,8} The Independent Public Inquiry into the case of Dr Harold

¹ V. Berridge, 'Drugs and social policy: the establishment of drug control in Britain, 1900-30', *British Journal of Addiction*, 79 (1984), 17-29.

² V. Berridge, 'War conditions and narcotics control: the passing of Defence of the Realm Act Regulation 40B', *Journal of Social Policy*, 19 (1978), 285-304.

³ V. Berridge, *Opium and the People* (Free Association Books, London: 1999) pp.235-270.

⁴ H. B. Spear (and ed. J. Mott), *Heroin Addiction Care and Control: The 'British System' 1916-1984* (London: DrugScope, 2002) p.35.

⁵ 1920 was the year of the Dangerous Drugs Act which required pharmacy inspections, and Gerald Rhodes gave that year for the establishment of the Inspectorate, but provided no source, see G. Rhodes, *Inspectorates in British Government. Law Enforcement and Standards of Efficiency*, Royal Institute of Public Administration (London: George Allen and Unwin, 1981) p.253. Margaret Stacey seemed confused by what she called the Home Office's 'drug squad' the origins of which she placed in the late 1960s, see M. Stacey, *Regulating British Medicine: the General Medical Council*, (Chichester: John Wiley and Sons, 1992) p.32.

⁶ P. Bean, 'Policing the medical profession: the use of Tribunals', in D. K. Whynes and P. T. Bean (eds.), *Policing and Prescribing. The British System of Drug Control* (Basingstoke: Macmillan, 1991) pp.60-70.

⁷ H. B. Spear, 'British experience in the management of opiate dependence' in M. M. Glatt and J. Marks (eds.), *The Dependence Phenomenon*, (Lancaster: MTP Press, 1982), pp.51-79.

Shipman carried out extensive research into how the regulatory systems for controlled drugs had developed since the nineteenth century, and published its findings in its *Fourth Report*.⁹ Given the nature of its interest, the Inquiry focussed on details of the legal and regulatory changes themselves, rather than seeking to explain the causes or wider effects of such developments.

The Home Office itself, through a combination of poor archiving practice and refusing the author access to Tribunal documents, has provided little in documentary material for study. Four annual reports were produced for a limited circulation in the mid-1980s and lodged with the library of the Institute for the Study of Drug Dependence (now DrugScope) in London, and a set of draft guidelines for Inspectors produced in 1983 were given to the author. In addition, a range of documents and oral evidence produced by the Inspectorate and police relating to the history of the supply of controlled pharmaceutical drugs considered by the Shipman Inquiry were made available on the Inquiry's Internet web site. Although reticent to provide documents, the Home Office were generous in granting extensive interviews. Four inspectors, including the current and most recent Chiefs, were interviewed for this chapter as well as a police Chemist Inspecting Officer and a former Chief of the Royal Pharmaceutical Society. As a result of the source materials available, the chapter gives greatest weight to the 1980s.

The Inspectorate's main concern through most of the twentieth century was to prevent diversion of an increasing range of controlled substances from authorised medical channels to unauthorised suppliers or users. It did this through a staff of inspectors originally based in London, and then with two additional regional offices from 1974.¹⁰ Spear attributed its origins to 'the belief that from time to time it might be necessary to make special enquiries, probably involving medical practitioners, for which it would be better not to employ the police.'¹¹ The police were to take a role in pharmacy inspection from 1917 but this sensitivity over who should patrol the medical profession recurred throughout the twentieth century. A preference for avoiding the criminal justice system when dealing with doctors' practices was certainly seen in the establishment of the Inspectorate's system of medical Tribunals. This was intended for disciplining doctors (and also vets and dentists) independent of the GMC if the Inspectorate thought they were supplying or prescribing dangerous drugs inappropriately. In addition to regulating prescribing doctors, the

⁹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.62-64; 278-279.

¹⁰ The Shipman Inquiry, *Fourth Report – The Regulation of Controlled Drugs in the Community* (London: HMSO, 2004) pp.43-56.

¹¹ A. Stears, Witness Statement, (31st August 1999), Document WS 34 00001, The Shipman Inquiry, www.theshipmaninquiry.org.uk.

¹² H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.35.

Inspectorate was responsible for policing the import, export, distribution and manufacture of controlled pharmaceutical drugs.¹²

The Inspectorate was just one strand in a web of control systems, both state and professional, which emerged over the twentieth century to regulate the fate of pharmaceutical 'dangerous drugs', known from 1971 as 'controlled drugs'.¹³ In addition to the GMC discussed in the previous chapter, this included the police's Chemist Inspecting Officers, the Regional Medical Service employed by Health Authorities, the Medicines Control Agency and the Royal Pharmaceutical Society's inspectorate, with professional and state systems working independently and cooperating informally with each other.

Early history of the Inspectorate

Prior to 1868, opium and other psychoactive substances were available for purchase through grocers' shops without any professional or state controls.¹⁴ The 1868 Pharmacy Act introduced minor restrictions on their sale through pharmacy shops, bringing a combination of state and professional control through the Pharmaceutical Society under the general supervision of the Privy Council Office.¹⁵

Berridge has noted a gradual tendency towards increased controls around availability and sale during the late nineteenth century, but that possession and use did not arouse concern. This light but rising professional/state regulation continued into the early twentieth century, with additional substances being brought under control, while opiate use was diminishing. At this time the addict population was small, made up largely of elderly opium users buying their supplies from chemists; a middle class section of morphine users whose drug use had usually originated with either medical treatment or occupational proximity to medical supplies; and a tiny artistic and Bohemian subculture, mainly in London, who smoked cannabis and opium.¹⁶

American influence on the international stage had led to Britain's reluctant involvement in the development of an international control system for narcotics, expressed in the Hague Conventions (1911-12, 1913 and 1914) which restricted opiate and cocaine use to that described as 'medical and

¹² J. Scullion, Witness Statement, (10th March 2003), Document WS 35 00001, The Shipman Inquiry, www.theshipmaninquiry.org.uk.

¹³ Under the Misuse of Drugs Act, 1971.

¹⁴ V. Berridge and G. Edwards, *Opium and the People. Opiate Use in Nineteenth Century England* (first published 1981 London: Allen Lane; this edition New Haven and London: Yale University Press, 1987) p.3.

¹⁵ *Ibid.* p.120.

¹⁶ V. Berridge, (1999) *op. cit.*, p.238.

legitimate', although this was not defined.¹⁷ Their implementation in Britain was initially proposed through professional regulation in alliance with the state, similar in style to the existing control mechanisms, but World War One invigorated the state's interest in narcotics control, as it did in other areas of personal behaviour, including alcohol consumption.

Concern about international smuggling and use of cocaine by soldiers led to an inter-departmental meeting in 1916 at which Sir Malcolm Delevingne, Under-Secretary dealing with aspects of drug issues at the Home Office since 1913, emerged as the dominant force. The meeting designated the drugs issue to be a police matter with central controlling authority at the Home Office,¹⁸ and Delevingne cemented his position over the next 20 years.

The legislation resulting from this meeting, Regulation 40B of the Defence of the Realm Act, passed in 1916, was much stricter than anticipated pre-war, making it an offence for anyone other than medical doctors, pharmacists and veterinary surgeons to possess, give or sell cocaine and opium (although not morphine), and it was the Home Office, not the pharmacy profession who became 'the initiator and arbiter of restriction'.¹⁹ From then on cocaine could only be supplied on prescription and importing cocaine and opium came under new Home Office controls. Berridge has characterised these legislative changes as resulting from a combination of press agitation through sensationalised, often inaccurate portrayals of the drug scene, a lack of opposition from leaders of the medical profession, under-representation of grass roots medical opposition to greater regulation, and a Home Office spurred on by Delevingne favouring a penal approach to drugs.^{20,21}

Further amendments to the Defence of the Realm Act (DORA) empowered the Home Secretary to withdraw a doctor's power to prescribe cocaine if he was convicted of an offence under the Act and controls on opiates followed. Home Office officials were detailed to monitor compliance and in 1917 this authority was extended to senior police officers. Pharmacists were for the first time required to keep records for inspection of the prescriptions they dispensed.²² The system of inspection was further developed by the Dangerous Drugs Act, 1920 and the Dangerous Drugs Regulations 1921.^{23,24} It was these legislative changes that gave the Inspectorate its powers and

¹⁷ *Ibid.* pp.241-245.

¹⁸ *Ibid.* pp.247-248.

¹⁹ V. Berridge, (1984) *op. cit.*, p.21.

²⁰ *Ibid.*

²¹ V. Berridge, (1978) *op. cit.*, pp.285-304.

²² H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.37.

²³ The Shipman Inquiry, (2004) *op. cit.*, pp.43-56.

²⁴ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.35-36.

created the control system it enforced. The Home Office Inspectorate also had a precedent in a regime of Home Office inspection under the unsuccessful Inebriates Acts of 1888 and 1898.²⁵

After the Versailles Peace Treaty (1919), the new League of Nations took on responsibility for international narcotics agreements, and the powers given to the state under DORA were extended in the 1920 Dangerous Drugs Act to cover heroin, morphine and 'medicinal opium'.²⁶ Police officers, who later became designated as 'Chemist Inspecting Officers', were responsible for inspecting records maintained by retail pharmacies from 1921 when the Dangerous Drugs Act came into force.^{27,28} Berridge portrayed the Home Office as successfully defending its penal approach in 1920 with the new Ministry of Health, representing a more liberal medical policy, coming off the worse from inter-departmental infighting. Potential opposition from pharmaceutical manufacturers was weak due to poor organisation and representation.^{29,30}

Spear has contested this interpretation of events, denying that the DORA regulation impinged upon medical freedom and downplaying the addition of later regulations as bringing greater restriction. Spear himself opposed a penal approach and defended the Home Office from being perceived as the source of this. As Chief of the Drugs Inspectorate, it was his role to see that these substances did not leak into the 'wrong hands',³¹ taking as self-evident this division between legitimate medical and illegitimate use.

A major change, brought by the Dangerous Drugs Act, 1920, and its regulations, was the effect on ordinary members of the public, to which Sir Malcolm drew the attention of Chief Constables in 1921:

*Chemists have hitherto been free to sell morphine, heroin, medicinal opium and their preparations to members of the public, without any restrictions other than the restrictions specified in Section 17 of the Pharmacy Act 1908. In future, sales to persons not specifically licensed or authorised will only be permissible on a prescription.*³²

²⁵ V. Berridge, (1984) *op. cit.*, p.21.

²⁶ M. Delevingne, Letter to Chief Constables re the Dangerous Drugs Act, 1920, and the regulations made thereunder, Home Office, Whitehall, (20th August 1921), Document WM 17 00736, The Shipman Inquiry, www.theshipmaninquiry.org.uk.

²⁷ *Ibid.*

²⁸ J. E. Hayzelden, Letter to Chief Officer of Police, Re Home Office Circular 25/1980 Inspection of Pharmacies, (12th March 1980), Document WM 17 00062, The Shipman Inquiry, www.theshipmaninquiry.org.uk.

²⁹ V. Berridge, (1978) *op. cit.*, pp.285-304.

³⁰ V. Berridge, (1984) *op. cit.*, pp.17-29.

³¹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.6.

³² M. Delevingne, (20th August 1921), *op. cit.*

Although some pharmacists continued to dispense opium-based preparations to elderly customers without prescription after the Act was passed.³³ Underlying these moves against free access to drugs were also cultural changes in the early twentieth century that, to some extent, diminished the acceptability of opiates and cocaine in society.³⁴ This can be compared with patterns seen in later settings, such as the United States in the 1980s, where restrictive legislation followed an existing decline in drug use.³⁵

Rolleston and beyond

At the time of the Rolleston Committee's deliberations (1924-26), it was not Home Office Inspectors or the police who inspected the supply of 'dangerous drugs', as they were then legally termed, but medical officials in the form of the Regional Medical Service of the Ministry of Health, in England and Wales, and the Medical Staff and District Medical Officers of the Board of Health in Scotland. (See Chapter 2 for more background on the Rolleston Committee). Regional Medical Officers (RMOs) had been given these powers in 1922, and although employed by the Ministry of Health, they were to act at the request of the Home Office to maintain doctors' compliance with the 1920 Dangerous Drugs Act and Regulations.³⁶

Doctors seemed able to claim preferential self-regulation over pharmacists, as according to the Rolleston Report, 'The records kept by wholesale chemists and by pharmacists are inspected by Home Office Inspectors or by the police; but it was considered preferable that those kept by medical practitioners should be inspected by medical officials.'³⁷ Furthermore, doctors employed by the state as RMOs were expected to give their primary loyalty to the profession over that owed to the state as Spear recorded that they were not expected to undertake any enquiry that could impair their relationship with general practitioners, for instance if it involved their giving evidence in court against a fellow member of the medical profession.³⁸

RMOs could be notified of a doctor in their area prescribing dangerous drugs by the Inspectorate or by police Chemist Inspecting Officers (CIOs) who inspected pharmacists' records. The RMOs

³³ S. Anderson and V. Berridge, 'Opium in 20th century Britain: pharmacists, regulation and the people', *Addiction*, 95 (2000), 23-36.

³⁴ V. Berridge, (1999) *op. cit.*, pp.236-239.

³⁵ See Working Party of the Royal College of Psychiatrists and Royal College of Physicians, *Drugs, Dilemmas and Choices* (Gaskell: London, 2000) pp.206-210.

³⁶ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.39.

³⁷ Departmental Committee on Morphine and Heroin Addiction, Report [Rolleston Report] (London: HMSO, 1926) p.5.

³⁸ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.39.

had been authorised since 1922 regularly to inspect records required by the 1920 Dangerous Drugs Act and Regulations and on the particular request of the Home Office.³⁹

In 1921, Sir Malcolm Delevingne explained that medical practitioners who dispensed their own medicines would be required to keep records of supplying dangerous drugs to patients and that,

The Secretary of State hopes that he will be able to arrange for occasional visits to be made by the Medical Officers of the Ministry of Health with a view to ensuring the observance by practitioners of the requirements of the Regulations, and that it will not be necessary as a general rule for the police to visit the residences of such practitioners for the purpose of inspecting their records.

It is not clear when Home Office inspectors took over the inspection of doctors entirely, but Spear noted that by 1952 Regional Medical Officers were seldom involved in drug enquiries, with the Inspectorate writing to doctors when pharmacy records revealed they had been prescribing dangerous drugs. The RMOs then returned to this activity in 1964 and continued until 1991 when the Regional Medical Service was abolished.^{40,41} Spear attributed these switches from using lay state employees to professional state employees and back in order to police prescribers to varying workloads of the different parties at given times and to sensitivities around lay and professional expertise.⁴² Certainly these sensitivities arose throughout the twentieth century in regulatory issues.

Regulatory Networks

Lay⁴³ State Mechanisms and Processes

In 1970 three mechanisms of state control dealing with prescribing controlled drugs existed: the Home Office Drugs Inspectorate ('the Inspectorate'), the police's Chemist Inspecting Officers ('CIOs'), and the Regional Medical Service (see Table 6.1). From 1989 the Medicines Control Agency also inspected pharmaceuticals for quality but was rarely involved in matters of controlled drug prescription and so is not discussed here.⁴⁴ The police and Inspectorate continued through the last decades of the twentieth century, with expansion of the Inspectorate and varying provision

³⁹ *Ibid.* p.39.

⁴⁰ *Ibid.* p.40.

⁴¹ The Shipman Inquiry, (2004) *op. cit.*

⁴² H. B. Spear (and ed. J. Mott), (2002), pp.39-40.

⁴³ Although the term 'lay' is used here to differentiate professional medical or pharmaceutical regulators from non-medical/pharmaceutical regulators trained 'on the job', it is clear that Home Office inspectors developed extensive expertise of their own which corresponds to the bureaucratic expertise described by Weber in M. Weber, (1964) *op. cit.*, pp.232-239.

⁴⁴ G. E. Appelbe, Interview by Sarah Mars, (2004).

of Chemist Inspecting Officers, but the RMOs faded out during this period. Liaison between these different agencies was informal.

The Inspectorate

In the early 1970s, inspectors visited doctors who were thought to be over-prescribing and they were still seeking advice from Regional Medical Officers (RMOs). From 1970 to 1973, if not dealing with the cases more informally themselves, the Regional Medical Service, in conjunction with the Home Office Inspectors and the police referred cases of irresponsible prescribing to the GMC, which was resistant to trying such doctors.⁴⁵

Table 6.1 Regulatory Bodies in the Supply of Controlled Drugs 1970-99

	Home Office ^{46,47,48,49}	Police ^{50,51,52}	Royal Pharmaceutical Society (RPS) ^{53,54}
Inspectors	Drugs Inspectorate	Chemist Inspecting Officers (CIO)	Pharmacy Inspectorate
Staff	Civil Servants	Police Officers	Mostly pharmacists employed by the Royal Pharmaceutical Society. Pharmacies only inspected by pharmacists.
Source of Regulatory Powers	1916 Defence of the Realm Act amendments 1920 Dangerous Drugs Act and 1921 Regulations; 1971 Misuse of Drugs Act	1920 Dangerous Drugs Act and 1921 Regulations; 1971 Misuse of Drugs Act.	Pharmacy and Poisons Act 1933, and Poisons Act 1972, Medicines Act 1968 and Misuse of Drugs Regulations, 1985.
Areas of Responsibility	Legitimate pharmaceutical industry Illicit drugs industry Medical profession Veterinary and Dentistry Professions	Pharmacies	Mostly community pharmacies. Some hospital pharmacies (those registered with the RPS). Powers to inspect other retail premises where medicines or poisons were sold. No responsibility for wholesalers or manufacturers or premises of doctors.

⁴⁵ Hansard, House of Lords, (14th January 1971), Vol 314, col. 245.

⁴⁶ A. Macfarlane, Interview by Sarah Mars, (2002).

⁴⁷ Home Office Inspector, Interview by Sarah Mars, (2002).

⁴⁸ V. Berridge, (1984) *op. cit.*

⁴⁹ The Shipman Inquiry, (2004) *op. cit.*

⁵⁰ N. Tilley, Interview by Sarah Mars, (2002).

⁵¹ H. Hampton, Interview by Sarah Mars, (2002).

⁵² The Shipman Inquiry, (2004) *op. cit.*

⁵³ S. Lutener, Interview by Sarah Mars, (2003).

⁵⁴ G. E. Appelbe, (2004) *op. cit.*

	Home Office	Police	Royal Pharmaceutical Society (RPS)
Areas of Concern	Diversion from legitimate medical use: Criminal supply "Irresponsible prescribing" Also criminal manufacture.	Diversion from legitimate medical use: Pharmacies Doctors	Professional conduct of pharmacists. (Criminal matters other than medicinal matters were referred to police.)
Regulatory Action	Visits by inspectors Tribunals (from 1973-97) Via GMC Via the courts Not a prosecuting authority itself.	Visits by inspectors Via Home Office Inspectorate Via GMC Via the courts	Visits by inspectors. Referral to RPS Disciplinary Committee which could give: Advice, Warnings, or Disciplinary action and removal from RPS register.
Inspection of	Prescriptions Pharmacies' controlled drugs registers Doctors Licensed manufacturers / distributors	Pharmacies' Controlled drugs register Prescriptions Doctors	Pharmacies and other retailers of pharmaceuticals.
Sources of information	Reports from: Doctors Drug users Public Chemist Inspecting Officers Other inspectorates. Addicts Index (up to 1997)	Own index. Home Office Inspectors Other inspectorates.	Any concerned professional, the public, police. Liaison with Chemist Inspecting Officers and occasionally Home Office Drugs Inspectorate.
Changes between 1970 and 1999	Diminishing of tools available for Inspectorate to gather information and, after 1994, to take disciplinary action. Removal of some duties to other agencies eg NCIS and GMC during 1980s and 1990s. Loss of role as key advisor to ministers.	1985-99: No major changes to system of pharmacy inspection, though some changes in focus. ⁵⁵ 1999: formal training under Home Office Inspectorate established.	Increase in formal training

⁵⁵ J. Scullion, ((10th March 2003) *op. cit.*

Spear described the Inspectorate's frustration when they lacked a Tribunal system, but also his powers of persuasion, in dealing with Dr Brennan, an elderly Portsmouth doctor who had been supplying local heroin addicts with *Diconal*. He 'would have been an ideal candidate for the Tribunal procedures for dealing with "irresponsible prescribing" included in the 1971 Act. But as these did not come into operation until July 1973 there was little the Drugs Inspectorate could do except try to persuade him to be more circumspect in his prescribing. After I "had a word" with Brennan he decided to have nothing further to do with addicts.'⁵⁶

After the Tribunal system was reintroduced, the role of the Regional Medical Officer diminished, but he or she could continue to advise the Drugs Inspectorate.⁵⁷ The focus of RMO enquiries, however, was to establish why the patient needed these drugs – whether for pain relief, which necessitated no further enquiry, or if the patient was addicted, which resulted in monitoring the case.^{58,59} This contrasted with the Inspectorate's later interests in the potential of drugs to be resold on the black market, the safety of quantities or formulations to the user, and, in private practice, the ability of the patient to pay doctors' fees.

After many years housed entirely in Central London, the Home Office gained two regional offices in 1974, dividing Britain into the Northern Region, policed from Bradford, covering the North of England and Scotland, the Midland Region, including Wales, the Midlands and the South West of England, with its office in Bristol, and the South East Region based in London. The purpose of regionalising the Inspectorate is not currently clear. Was it intended to respond more efficiently to prescribing outside London or was it perhaps unrelated to drugs issues, for instance a civil service management decision to create jobs outside London? The regionalisation did result in the establishment of meetings for groups of consultants working in the regional DIDUs, perhaps counterbalancing the dominance of the London Clinics and their expertise.

The 1970s also saw the Inspectorate offer the Home Office as the new venue for the London Consultants Group (LCG) meetings. The LCG was composed of (usually consultant) psychiatrists representing the London Clinics and surrounding area and had been meeting since 1968. They had moved from their initial meeting place of the Department of Health due to perceived interference from civil servants in their decision-making (see Chapter 8). These meetings were attended regularly by either Spear or one of his inspectors who received information on problem prescribers working

⁵⁶ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.260.

⁵⁷ L. Hay, Interview by Sarah Mars, (2003).

⁵⁸ *Ibid.*

⁵⁹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.40-41.

outside the Clinics and provided advice and information.⁶⁰ Inspectors could also advise the LCG of any difficulties with their own members which they might wish to address themselves, although this was rare. Unlike doctors outside the Clinics, they seemed to enjoy the privilege of informal self-regulation while trying, often successfully, to set the standards by which other doctors were judged (see Chapter 8).⁶¹

The Association of Independent Doctors in Addiction (AIDA) might have performed a similar function. It was set up with Bing Spear's encouragement and initially met with Spear in attendance at the Home Office, until it was forced to move from government offices and AIDA broke up after Dally's second GMC hearing in 1988. Unlike the Clinic doctors, who worked in the same medical hierarchy, private doctors had no interdependency or perceived shared self-interest; the reasons for this are discussed in detail in Chapter 8.

In addition to this attempt to encourage self-regulation among doctors outside the Clinics, the Inspectorate's state regulation continued. In 1985 228 practitioners were visited by inspectors,⁶² and this increased from that year. According to one inspector, more visits were made after 1985 because 'it was one of our operational priorities and we were trying to encourage doctors to prescribe responsibly'.⁶³ This also coincided with the appointment of Donald McIntosh as Senior Inspector in the South East Region who raised the number of interviews with private prescribers. By 1988 Peter Spurgeon, Chief Inspector from 1986-89, claimed that 'in any one year my Inspectors interview some 300 doctors about the safeguards necessary to minimise the risk of diversion'.⁶⁴

The difference in approach taken by Don McIntosh towards private prescribers has been attributed to the disparity between London and Bradford, and Mr McIntosh's desire to see equal standards applied in the South East. He was dubious about the role of private prescribers in the treatment field and once in post as Senior Inspector in the South East Region, launched a campaign to regulate the private prescribers more rigorously.⁶⁵ This included writing a report recommending that Dr Dally be taken to a Tribunal (see Chapter 7). However, Spurgeon saw McIntosh as simply

⁶⁰ Home Office Inspector, (2002) *op. cit.*

⁶¹ *Ibid.*

⁶² Home Office Drugs Branch Inspectorate, *Annual Report 1985* (London: Home Office, 1986) Ref. 52186, DrugScope Library, London, p.11.

⁶³ J. Scullion, Transcript of Day 149, (27th June 2003), The Shipman Inquiry, www.theshipmaninquiry.org.uk.

⁶⁴ P. G. Spurgeon, Letter to all Chief Police Officers Re Notes for Chemist Inspecting Officers, (17th March 1988), Document WM 17 00163, The Shipman Inquiry, <http://www.theshipmaninquiry.org.uk>.

⁶⁵ Home Office Inspector, (2002) *op. cit.*

reflecting established treatment orthodoxy, which Spear, with the exceptional respect he was accorded, was able to speak out against.⁶⁶

The Inspectorate was the first arm of British government to develop extensive expertise in drug misuse, before the Ministry of Health. Prior to the expansion of external research on drug misuse in the 1980s, it was one of the few agencies able to gather data on drug misuse 'on the streets', employing roving inspectors in the years before the proliferation of street agencies for drug users. For this reason it played an important role in providing policy advice to ministers, and constituting a major influence in the regulatory battles between private and NHS prescribers during the period up until the departure of Spear in 1986, after which the Inspectorate's influence waned. The uniqueness of the Drugs Inspectorate should not be overstated though: the role of policy advisor to ministers was one which was also developed by other central government inspectorates, such as the railway inspectors advising the Department of Health on wider transport policy,⁶⁷ and was in accord with Weber's description of self-perpetuating bureaucracies.⁶⁸

Within the policy community, the Inspectorate gathered and relayed information about all aspects of prescribing controlled drugs. Although perceived, at least during Spear's time, as a neutral force, trusted by all sides, the Inspectorate had its own policy goals, which it fostered through the encouragement of particular doctors working outside the Clinics, and by opposing the extension of opioid licensing in 1984 in advice to ministers (see Chapter 4). While at the Inspectorate Spear was circumspect in expressing his views he became more outspoken in retirement, describing the way the Clinics were implemented as 'an unmitigated disaster'.^{69,70} The power of the Clinics' leaders was perhaps reflected in the extent to which the Inspectorate was bound to accept them as setting the standards of acceptable treatment, despite Spear's own views and, as Bean has observed, Tribunals were never used against Clinic doctors for irresponsible prescribing.⁷¹ On the converse side, they sometimes failed to gain policy changes opposed by Spear.

Home Office Licences

In addition to Tribunals, the Inspectorate wielded another regulatory tool: the licensing system which controlled who could prescribe certain drugs in the first place, rather than stopping them, as

⁶⁶ P. Spurgeon, Interview by Sarah Mars, (2004).

⁶⁷ G. Rhodes, (1981) *op. cit.*, p.171.

⁶⁸ M. Weber, *From Max Weber: Essays in Sociology*, H. H. Gerth and C. Wright Mills (eds.), (New York and Oxford: Oxford University Press, 1946, this edition, 1964) pp.228-240.

⁶⁹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.310.

⁷⁰ D. Musto, 'Bing Spear: Appreciations', in H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.viii-ix.

⁷¹ P. Bean, (1991) *op. cit.*, p.65.

the Tribunal system did, after the fact. From 1968, on the recommendation of the second Brain Committee, doctors wanting to prescribe heroin or cocaine (and from 1984 dipipanone) for the treatment of addiction were required to apply to the Home Office for their licence (see Chapter 2).⁷² Although the Home Office seemed to have the power to decide who received licences, their ability to rescind them was successfully challenged.

The Home Office almost exclusively granted the licences to psychiatrists working in the new NHS Clinics and only two or three doctors were ever licensed to prescribe heroin privately.^{73/74} One of them, Dr Kanagaratnam Sathananthan, consultant psychiatrist at Croydon DDU, received his licence in the 1980s, probably with Spear's support,⁷⁵ and although the Inspectorate later tried to withdraw his licence, the doctor's appeal to the Home Secretary succeeded and he continued to prescribe heroin privately throughout the period.^{76,77}

From 1968, there had been a series of unsuccessful attempts using different policy fora and originating with the London Clinic consultants, to extend the Home Office's licensing powers and further restrict the prescribing powers of doctors outside the Clinic system, with the Home Office at first opposing and then supporting these moves (see Chapters 4 and 7).

It is likely that Spear opposed the extension of licensing in 1984 and certainly the advice given by his department to ministers was intended to dissuade them and seemed to succeed.⁷⁸ A further effort to extend licensing to cover all injectable opiates and restrict licences to 'doctors working in, or under the direct supervision of, a consultant or equivalent in a clinic' was made in 1985 through the Social Services Committee.⁷⁹ In its response the Government cited rather misleadingly optimistic trends in prescribing from figures prepared by Spear's department (see Chapter 4).^{80/81,82}

⁷² Interdepartmental Committee on Drug Addiction, *The Second Report of the Interdepartmental Committee* (London: HMSO, 1965) pp.7-9.

⁷³ Department of Health and Social Security, Department of Education and Science, Home Office and Manpower Services Commission, *Misuse of Drugs with Special Reference to the Treatment and Rehabilitation of Misusers of Hard Drugs: Government Response to the Fourth Report from the Social Services Committee Session 1984-85* (London: HMSO, 1985) pp.18-19.

⁷⁴ A. Macfarlane, (2002) *op. cit.*

⁷⁵ Spear wrote sympathetically about Sathananthan in his book and was Chief Inspector when the licence was granted. See H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.245.

⁷⁶ A. Macfarlane, (2002) *op. cit.*

⁷⁷ K. Sathananthan, Interview by Sarah Mars, (2001).

⁷⁸ Home Office, MWG (84) 33, 'Power to restrict licences to prescribe under Misuse of Drugs Act 1971', (1984) Private archive.

⁷⁹ House of Commons Social Services Committee, *Misuse of Drugs with Special Reference to the Treatment and Rehabilitation of Misusers of Hard Drugs. Fourth Report of the Social Services Committee, Session 1984-85* (London: HMSO, 1985) p.xxv.

⁸⁰ Anonymous, 'Prescription analysis: opioids 1974-1983', Annex to R. Witney, (22nd November 1985) *op. cit.*

⁸¹ D. Mellor, Letter to R. Whitney, (10th December 1985), File 16/DAC 28/2, DH Archive, Nelson, Lancashire.

Under Spear the Inspectorate was a key source of advice to ministers on drug policy and used its position to push a harm reductionist agenda and prevent the Clinics gaining a stranglehold on prescribing. In the 1990s the Inspectorate took a very different view. Alan Macfarlane took over as Chief Inspector in 1990 and under his leadership the Inspectorate made alliances with London consultant psychiatrists and the Department of Health in order to extend opioid licensing and increase its regulatory powers against private prescribers and GPs.

Unlike Spear, who was well known for his personal interest in the welfare of drug users, and doctors' clinical autonomy, Macfarlane's interest was more heavily weighted towards controlling the drugs supply, and preventing diversion, and less to the provision of treatment. Under Alan Macfarlane's leadership the Inspectorate pursued a Misuse of Drugs Tribunal against private prescriber Adrian Garfoot that turned into something of a fiasco as it wore on from 1993 to 1997. Presumably frustrated by this lengthy and expensive attempt at regulation, Macfarlane expressed his dissatisfaction with the Inspectorate's existing tribunal procedures for tackling 'irresponsible prescribing', describing them as 'cumbersome in the extreme'.⁸³

Macfarlane saw the preparation of the third edition of the clinical guidelines (1996-99), backed up by (another attempt to extend) licensing, as an opportunity to streamline these procedures and acquire an enforceable standard for prescribing.⁸⁴ Dr Anthony Thorley, the Senior Medical Officer responsible for drugs at the Department of Health in 1996, was in accord with Alan Macfarlane on this issue, along with Professor John Strang, Chairman of the Clinical Guidelines Working Group (see Chapter 7).^{85,86}

Despite some opposition within the Clinical Guidelines Working Group,⁸⁷ the principles of the licensing extension were proposed in 1999 by the Working Group in its confidential report to ministers, as intended by the Home Office, Department of Health and Professor Strang. The operational details were then drawn up by the Home Office Drugs Inspectorate and sent to a range

⁸³ J. Patten, Letter to D. Mellor, (15th May 1985), File 16/DAC 28/2, DH Archive, Nelson, Lancashire.

⁸⁴ A. D. Macfarlane, CGWG (97) 3, 'Pharmaceutical Diversion and the Prescribing Dimension. Note by the Home Office Drugs Inspectorate', (3rd March 1997), Private archive.

⁸⁵ *Ibid.*

⁸⁶ A. Thorley, Interview by Sarah Mars, (2002).

⁸⁷ A. Thorley, CGWG (97) 17, 'Clinical Guidelines Working Group (attached to CGWG(97)17 'Note by the Home Office on Licensing'), Home Office Licensing: The Options for Encouraging Good Clinical Practice', (May 1997), File 16 TFD-46 Vol. 5, DH Archive, Nelson, Lancashire.

⁸⁸ C. Ford, Interview by Sarah Mars, (2002).

of organisations for consultation.⁸⁸ This alliance brought the licensing proposals further along the path to implementation than ever before but five years on the consultation had come to nought and the proposals had yet to be implemented.

Self-regulation, albeit under the threat of state regulation, seems to have won out. The perceived need for licensing may have been lessened by the Royal College of General Practitioners establishing a 'Certificate in the Management of Drug Misuse' in 2000 to improve levels of training among their members. In 1984 the same licensing proposals may have been dropped due to two factors which were also present in 2001: opposition from GPs keen to guard their clinical autonomy and fears in government that greater restrictions on prescribing would put off reluctant GPs from treating drug users.^{89,90} The history of the licensing issue may also point to the Inspectorate's shrinking influence within the policy community after Spear's departure. Aside from the loss of Spear's personal knowledge from the Inspectorate, expertise on drugs proliferated both outside and inside government independent of the Inspectorate. Furthermore, GP opinions gained greater weight as they provided a larger proportion of drug treatment compared with the specialist Clinics, so their prescribing freedoms were not to be withdrawn lightly. Government alliances with psychiatry were therefore less effective than they might have been in the late 1960s and 1970s.

Tribunals and Home Secretary's rulings

Under the Regulations of DORA and the later 1920 Dangerous Drugs Act and 1921 Regulations, the Home Secretary had the power to withdraw medical practitioners' (and dentists and veterinary surgeons') authority to possess and supply drugs for their professional purposes if they had contravened the legislation. While some diversion of drugs from intended recipients could be identified fairly easily as non-medical and therefore as criminal by contemporary definitions, resulting in action taken by the Home Office through the courts, there was uncertainty over what sort of prescribing could be considered as not for the purpose of medical treatment: did this include drugs purely to satisfy the cravings of addiction? Did it cover sending prescriptions in the post to patients not seen for long periods of time?

In the early years of the Inspectorate, there was uncertainty over whether a patient who had originally been prescribed drugs for a medical condition and had become dependent upon them

⁸⁸ A. Macfarlane, 'Changes to the misuse of drugs legislation of controlled drugs prescribe in the treatment of addiction', [Consultation document] (London: Action Against Drugs Unit, Home Office, 17th March 2000).

⁸⁹ eg. A. Banks, Letter to N. Fowler, MP, (1983), Ref. 40117, DrugScope Library, London.

⁹⁰ eg. B. Beaumont, T. Carnworth, W. Clee, *et al.*, 'Licensing doctors counters the National Strategy', *Drugslink*, 15(6) (2001), 25.

once the medical condition had passed should still receive them merely for the relief of addiction. According to the Rolleston report, this uncertainty over matters which 'must turn largely on questions of medical opinion' made the Home Office reluctant either to prosecute doctors or to bring a case to the GMC for conduct "infamous in a professional respect".⁹¹ Preference for a Tribunal system was also expressed by the British Medical Association.

While avoiding the courts had obvious advantages for a doctor, who could not be given a criminal record by a Tribunal, it was not so obvious why a Tribunal should be preferable to a hearing in front of the GMC. Both panels were manned by doctors. There may have been two reasons: the Home Office Tribunals were held in private, while the GMC hearings were open to the press and public and before 1970, when the penalty of suspension of registration was introduced,⁹² the GMC's only sanction was the drastic one of erasure from the register. By contrast the harshest penalty the Home Office could apply was removal of the right to prescribe dangerous drugs, leaving the doctor still able to practice most areas of medicine.

The Rolleston Report therefore advised that for these cases, special medical Tribunals be set up so that a doctor could be judged by his peers instead of the courts, a proposal which offered 'several advantages, both administratively and from the point of view of the medical profession'. The benefits to the profession over criminal prosecution were clear, as the Tribunals were in part to enable the withdrawal of authorisation 'without recourse to those penalties of fine and imprisonment which the magistrates have the power to inflict.' These Tribunals again maintained the idea of exclusive professional expertise considered by the Committee to be lacking in a lay magistrate.⁹³

The law was amended to include these new regulations under the 1926 Dangerous Drugs Act so that the Secretary of State could refer the case of a doctor to a Tribunal if they were supplying, administering or prescribing any of the drugs other than for the purposes of medical treatment. However, the provisions were never used and then removed in 1953 pending agreement with the medical profession about new procedures.⁹⁴ Neither Spear nor Bean could produce evidence to explain this, but Bean speculated that 'the hand of the General Medical Council will be seen to be at

⁹¹ Departmental Committee on Morphine and Heroin Addiction, (1926) *op. cit.*, p.8.

⁹² R. G. Smith, *Medical Discipline: The Professional Conduct Jurisdiction of the General Medical Council, 1858-1990* (Oxford: Clarendon Press, 1994) pp.168-169.

⁹³ Departmental Committee on Morphine and Heroin Addiction, (1926) *op. cit.*, p.24.

⁹⁴ P. Bean, (1991) *op. cit.*, pp.62-63.

work here, for the Tribunals would have controlled the profession's prescribing activities, almost unheard of at that time.⁹⁵

The first Brain Committee thought the Tribunal system unnecessary and it was not reintroduced until the Misuse of Drugs Act, 1971, which came into force in 1973.⁹⁶ Under this Act, directives by the Home Secretary could be applied under Section 12, for criminal offences, most of which concerned dependent doctors diverting supplies for their own use, and Section 13, for non-criminal prescribing issues. Spear saw the reintroduction of Tribunals as essential, 'plugging this gaping hole in our control machinery'⁹⁷ and credited it to the Amphetamines Sub-committee of the Advisory Committee on Drug Dependence which had recommended bringing back the system originally described by the Rolleston Committee. Tribunals were considered necessary by Parliament because the Government accepted the GMC's complaint that its own machinery was inadequate and therefore declined to discipline irresponsible prescribers itself.^{98,99,100} As shown in the previous chapter, the GMC was later to become more enthusiastic in prosecuting such prescribers itself, despite the lack of a relevant change in its jurisdiction or the addition of any surveillance function.

Injudicious or irresponsible prescribing was defined during the passage of the Misuse of Drugs Act as 'careless or negligent prescribing or unduly liberal prescribing with bona fide intent'.¹⁰¹ The law itself contained no definitions, and the GMC's similarly vague statement 'the prescription or supply of drugs of dependence otherwise than in the course of bona fide treatment'¹⁰² enabled both regulatory authorities to interpret the term subjectively and according to the changing trends in treatment. To facilitate its task of enforcement in an ambiguous situation, the Drugs Inspectorate was to make a number of strategic alliances with the Department of Health and senior members of the medical profession throughout the period.

The Tribunal itself consisted of four medical members nominated by a number of medical bodies: the Royal Colleges, the GMC or the BMA and a Queen's Council barrister acting as chairman. It was considered a quorum at the chairman and two members. The proceedings, unlike those of the GMC disciplinary committee, were held in private, with a format similar to a law court: a lawyer

⁹⁵ *Ibid.* p.62.

⁹⁶ *Ibid.* p.65.

⁹⁷ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.62.

⁹⁸ Hansard, House of Lords, (14th January 1971), Vol 314, col. 245.

⁹⁹ Hansard, House of Lords, (14th January 1971), cols 229-30, quoted in P. Bean, (1991) *op. cit.*, p.64.

¹⁰⁰ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.62.

¹⁰¹ Hansard, (25 March 1970), cols 1457-8, quoted in P. Bean, (1991), *op. cit.*, p.64.

¹⁰² R. G. Smith, (1994) *op. cit.*, p.39.

each representing the doctor and the Home Office, with evidence being presented and cross-examined.

Tribunals could be used in a variety of ways: the threat of tribunal proceedings could be used to persuade doctors to change their practices, as with Dr Dally in 1986;¹⁰³ doctors summoned to a Tribunal might remove themselves from the medical register before the proceedings got underway so that they did not have to suffer the ordeal itself, or in their full manifestation followed by an acquittal or a ruling by the Secretary of State to modify prescribing powers.¹⁰⁴ A successful prosecution could also be appealed. Between 1973 and 1999 the system was used only once against a Clinic doctor, and this was for criminal offences relating to the supply of drugs rather than irresponsible prescribing.^{105,106}

The system came to an end as a result of one particular case – that of Dr Adrian Garfoot – a private GP who had worked with drug users for several years and had developed views similar to Dr Dally's regarding reform of the drug control system and what he saw as the oppressed position of drug users in society. Although the Home Office, after delays over several years, had succeeded in proving its charges during the Tribunal, a successful appeal on procedural grounds by Garfoot's lawyers overturned the ruling in 1997. After what was for the Home Office a humiliating and costly defeat, Tribunals were never used again. The Home Office's official account of the reasons for their ceasing to use the Tribunal mechanism was given in the 2002 edition of its *Guidance to Chemist Inspecting Officers*:

*It became clear during the 1990s that these powers [under sections 13-16 of the Misuse of Drugs Act] were no longer an effective mechanism and the last case was referred for Tribunal action in 1993. The practitioner involved, Dr [Garfoot], was able to delay the hearing for over a year, by which time he had engaged other doctors to undertake prescribing at his clinic. Subsequently it has become apparent that the legislation is deficient in several aspects of Human Rights, thereby removing any remaining possibility that the powers could be reactivated.*¹⁰⁷

This left the Inspectorate in a similar position to the early 1970s, able to advise doctors, and gather evidence, but without its own disciplinary function. Yet this time the GMC took a much more active approach to regulating prescribers, taking non-Clinic doctors to its Professional Conduct

¹⁰³ A. Dally, (1990) *op. cit.*, pp.149-151.

¹⁰⁴ L. Hay, (2003) *op. cit.*

¹⁰⁵ Home Office Inspector, (2002) *op. cit.*

¹⁰⁶ L. Hay, (2003) *op. cit.*

¹⁰⁷ Home Office, *Guidance to Chemist Inspecting Officers*, (Home Office, London: 2002), Document WM 17 00388, The Shipman Inquiry, www.theshipmaninquiry.org.uk.

Committee and by the turn of the twentieth century was erasing quite a number of private prescribers from its register, including Dr Garfoot in 2001. With a reinvigorated GMC, the Inspectorate reduced its work with doctors, cutting down the number of interviews to 'a handful'.¹⁰⁸ Although there remained co-operation between the state and the profession in regulating non-Clinic doctors, the processes were more weighted towards self-regulation, albeit under the watchful eye of politicians.

The Addicts Index

The Addicts Index was a list of patients believed dependent on opiates or cocaine who were known to the Home Office. The Drugs Inspectorate was the 'custodian and principal user' of the Addicts Index, which had been kept centrally as a formal record since 1934, probably at the request of the Opium Advisory Committee of the League of Nations in 1930.¹⁰⁹ Inspectors also had a role in ensuring that doctors were notifying patients dependent on opiates or cocaine to the Index, as they were legally obliged to do from 1968. In that year, the annual addict statistics and the drug offence statistics that the Inspectorate had produced was passed to the Home Office Statistical Branch.¹¹⁰ The name, drug(s) of addiction and any controlled drugs prescribed were listed on the Index so that, in theory, any doctor prescribing to the notified addict could check with the Index to see whether they were already receiving a prescribed supply from another source, and so prevent patients from 'double scripting'. In practice there was often a long delay between notification and entry of the data onto the Index, with computerisation in the 1980s only adding to these difficulties. In 1982 there was about a three month delay between notification by a doctor and entry onto the Index when staff was cut at the same time as an increase in notifications.¹¹¹

Notification could form the first indication of a new doctor treating drug users or checking a patient's previous notification. Although doctors phoning up the Index would speak to lay administrative staff, not inspectors, the information reached was used by the inspectors. The Index was closed in 1997 as a cost-cutting measure, against the advice of the ACMD,¹¹² and statistical information on drug users in treatment was gathered instead from non-compulsory notifications to the Regional Drug Misuse Databases without the names of patients, which were then published centrally by the Department of Health.

¹⁰⁸ Home Office Inspector, (2002) *op. cit.*

¹⁰⁹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.41.

¹¹⁰ *Ibid.* p.41.

¹¹¹ GMC Professional Conduct Committee, Day Three, (8th March 1984), Case of Tarnesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. p.9.

¹¹² ACMD member, Personal communication, (1997).

The end of the Addicts Index meant the loss not only of a source of statistical data on trends in drug use and treatment, but also a regulatory tool from the Inspectorate as it provided a window onto doctors' prescribing and an early warning system for any new doctor who might require an inspector's visit.

Chemist Inspecting Officers (CIOs)

Police were empowered to monitor compliance with DORA in 1917, and it was the 1920 Dangerous Drugs Act that gave them responsibilities to inspect retail pharmacy records in 1921. CIOs were charged with inspecting the controlled drug registers of pharmacies to check for any irregularities in stock and the dispensing of dangerous drugs. The Shipman Inquiry traced a change from 1921, when CIOs focussed mainly on compliance with the 1921 Dangerous Drugs Regulations, to 1939 when police were also instructed to look at what individual patients were receiving and were seeking to identify addicts.¹¹³ After 1971 their power to carry out these duties derived from Section 23 of the Misuse of Drugs Act.¹¹⁴ It was not until 1999 that they received formal dedicated training,¹¹⁵ although the Home Office had told police chiefs that it was 'willing to assist' with the police's own training of CIOs in 1980.¹¹⁶

The controlled drug registers in chemist shops recorded all the controlled drugs dispensed and the patients to whom they were prescribed; it was the task of CIOs to check these registers to ensure that all the drugs processed by the pharmacist were accounted for and none could have leaked out to an unauthorised party. Any inconsistencies would be investigated and could lead to criminal prosecution for the pharmacist or referral to his/her professional body, the Royal Pharmaceutical Society of Great Britain (RPS). These registers also allowed CIOs to discern prescribing patterns, passing information to the Inspectorate for possible further action if it matched those considered questionable by the Home Office, who might then contact the doctor involved.¹¹⁷ Criminal matters detected by CIOs would be dealt with by the police, rather than the Inspectorate, but issues of prescribing style would be referred to either the Home Office or GMC.

Tension between the police and the Inspectorate over chemist inspections bubbled up almost immediately with the police reluctant to undertake these duties.¹¹⁸ On the other side, the Inspectorate, reliant on CIOs for information from pharmacists' controlled drug registers, were

¹¹³ The Shipman Inquiry, (2004) *op. cit.*, pp.45-48.

¹¹⁴ J. E. Hayzelden, (12th March 1980) *op. cit.*

¹¹⁵ J. Scullion, (10th March 2003) *op. cit.*

¹¹⁶ J. E. Hayzelden, (12th March 1980) *op. cit.*

¹¹⁷ *Ibid.*

¹¹⁸ The Shipman Inquiry, (2004) *op. cit.*, pp.45-46.

often frustrated with the inconsistency of the data supply. The regional structure of the British police meant that each police force determined the resources allocated to Chemist Inspecting Officer posts. Many regional forces saw the provision of CIOs as a low priority, leading to patchy cover across the country and a back and forth debate as to whether the Inspectorate should relieve the police of responsibility for pharmacy inspections. In 1979 the issue was put to the police's Central Conference Committee, who endorsed continued police provision of CIOs.

However, despite central policy, the problems seem to have persisted as Spear complained in 1986 that 'we cannot rely on the police inspections of retail pharmacies to provide the essential information of what has been prescribed and to whom, particularly in the Metropolitan Police District where most of the cases occur.'¹¹⁹ The question of whether pharmacy inspection should be the duty of police or the Inspectorate was still being discussed in 1989 and 1993, with police officers, in North Wales at least, considering that the main beneficiaries of their workload was the Inspectorate.^{120,121} The Inspectorate still considered much of the CIO inspecting unsatisfactory in 1996 and approached the Association of Chief Police Officers with its concerns.¹²²

The reluctance of police forces to appoint dedicated CIOs was probably partly because it was the Inspectorate who had overall responsibility for CIO inspections and set their investigative priorities, rather than the chief police officers of the regional forces; it was the Home Office who drew up guidelines for CIOs.¹²³ More than one regional police force commented in 1993 that little or no useful intelligence was gained from these inspections and the only people who benefited from them were the Home Office Drugs Inspectorate.^{124,125} Peter Spurgeon (Chief Inspector 1986-89) attributed the low priority given by forces to the CIO role partly to the huge expansion in the trafficked and illicitly manufactured market, in the light of which police officers with any expertise in controlled drugs were transferred to dealing with that criminal market, rather than the smaller and perceived lesser issue of pharmaceutical drugs.¹²⁶

¹¹⁹ Home Office Drugs Branch Inspectorate, (1986) *op. cit.*, p.12.

¹²⁰ North Wales Police, Memorandum on Inspection of Retail Pharmacies, (5th January 1989), Document GA 22 00078, The Shipman Inquiry, www.theshipmaninquiry.org.uk.

¹²¹ North Wales Police Headquarters Drugs Branch, Inspection of Retail Pharmacies, (28th September 1993), Document GA 22 00076, The Shipman Inquiry, www.theshipmaninquiry.org.uk.

¹²² Shipman Inquiry, Transcript of Day 148, (26th June 2003), The Shipman Inquiry, www.theshipmaninquiry.org.uk.

¹²³ Home Office, *Inspection of Retail Pharmacies*, (London: Home Office, 1981), Document WM 17 00082, The Shipman Inquiry, www.theshipmaninquiry.org.uk.

¹²⁴ Anonymous [names deleted], Police memorandum sent to ACPO Crime Committee, (1st October 1993), Document Ref. GA 22 00075, The Shipman Inquiry, www.theshipmaninquiry.org.uk.

¹²⁵ North Wales Police Headquarters Drugs Branch, (28th September 1993) *op. cit.*

¹²⁶ P. Spurgeon, Interview by Sarah Mars, (2004).

Professional Mechanisms and Processes

While the Inspectorate and police provided state supervision over prescribed controlled drugs, the Royal Pharmaceutical Society and the GMC regulated their own professional members.

The Royal Pharmaceutical Society and the General Medical Council

The Royal Pharmaceutical Society's inspectorate inspected all pharmacies in Britain.¹²⁷ Unlike the GMC, which lacked its own inspectors, the RPS established its own disciplinary procedures in 1935 and its inspectorate in 1936 following the 1933 Pharmacy and Poisons Act. Under the Act only registered pharmacists could inspect pharmacies for the Society to check their compliance with professional standards, although non-pharmacists were later employed to inspect other retail premises selling pharmaceuticals. Pharmacist-only inspection would seem to protect the self-regulation model but the fact that they were simultaneously being inspected by police officers undermined this, and the result was combined professional and state regulation, as had existed to a lesser degree from 1868. RPS inspectors often worked together with police officers, and occasionally Home Office inspectors. While there was frequent criticism of CIOs from the Home Office, Peter Spurgeon remembered the RPS as 'a highly professional lot' with whom the Inspectorate's relations were good.¹²⁸

Like the Inspectorate, the RPS inspectors had the role of both advising and potentially disciplining the pharmacists they visited. Professional guidelines and legislation provided the standards, as well as formal and informal training. If these regulations or guidelines had been breached, RPS inspectors could either warn a pharmacist on site or follow up with more formal procedures. Unlike the GMC, the RPS not only used its own disciplinary body, the 'Statutory Committee', but could also choose to prosecute through the law courts. Like the GMC, a criminal conviction could then result in a disciplinary hearing before the Statutory Committee to see whether the pharmacist should remain on the register.

The GMC and its role in regulating prescribing were discussed in detail in Chapter 5. In relation to the other bodies discussed here, the Council's main role was to prosecute, through its disciplinary procedures, cases brought to light by the Home Office Inspectorate, the Chemist Inspecting Officers, or occasionally, the Royal Pharmaceutical Society's inspectors. It also suggested 'experts'

¹²⁷ G. E. Appelbe, (2004) *op. cit.*

¹²⁸ P. Spurgeon, (2004) *op. cit.*

from the Clinics to advise Chemist Inspecting Officers about acceptable prescribing, at least from the mid-1980s onwards.¹²⁹

Between 1968 and 1999, there were fluctuations in the levels of disciplinary action against doctors by the GMC and the Inspectorate, and in which organisation took the lead. Until 1968, the GMC had dealt with a mere handful of cases of 'non bona fide prescribing' of controlled drugs. After that date, the numbers increased, but remained at less than 10 per year until at least 1990.¹³⁰ From 1968-73, the GMC was the only regulatory body able to take disciplinary action for 'irresponsible prescribing', although warnings could be given by the Inspectorate and the Regional Medical Officers (see above).

It seems that during the 1980s and for much of the 1990s, the Inspectorate took the lead in disciplinary cases against doctors prescribing controlled drugs.¹³¹ However, after the 1997 'watershed' of Adrian Garfoot's successful appeal against his 1994 tribunal ruling, the GMC took over the job of prosecuting all the cases made by the Inspectorate's investigations and the Tribunal machinery was left unused. Compared with 1968-72, the GMC was this time much more willing to take on the role of prosecuting errant prescribers, and this may have been due to government and public pressure on the profession to prove its ability to self-regulate (see Chapter 5).

Internal and External Expertise

The Inspectorate's work focused entirely on controlled drugs, rather than the whole range of doctors' professional behaviour, and it developed its own internal expertise and views on appropriate prescribing and the implications for the demand and supply of both pharmaceutical and trafficked drugs. These included the particular formulations and substances likely to be diverted, their black market values, and the health risks particular drugs posed when not used as prescribed. However, the Inspectorate never employed any doctors or pharmacists and as lay inspectors without medical or pharmaceutical training, they were keenly aware of the sensitivity of commenting on the well-defended turf of doctors' clinical judgement, relying upon external sources of medical advice to support and legitimise their judgements.

While there was no official definition of the 'irresponsible' prescribing that the Inspectors were supposed to police, they had drawn up their own guidelines on what to look for when visiting

¹²⁹ N. Tilley, Interview by Sarah Mars, (2002).

¹³⁰ R. G. Smith, (1994) *op. cit.*, p.104.

¹³¹ Home Office Inspector, (2002) *op. cit.*

¹³² eg. A. Dally (1990) *op. cit.*, p.134.

prescribers.¹³³ During the 1980s, advice was sought from some of the London consultants and their publications, such as those by Martin Mitcheson, consultant psychiatrist at University College Hospital.¹³⁴ In 1984, South East Regional inspector John Lawson, was asked at a GMC hearing what features of a particular doctor's prescribing led to the setting up of a Misuse of Drugs Tribunal. He replied that it was the amount of drugs prescribed for individual patients, but that they did 'seek expert advice' on that.¹³⁵ After 1984, the Inspectorate could also use the medically produced Department of Health clinical guidelines.^{136, 137, 138, 139}

However, when considering whether to take Dr Dally before a Tribunal in 1983, the Inspectorate decided against, while the GMC pursued what was a rather weak case amid attacks in the medical press on private prescribing by London Clinic psychiatrists (see Chapter 5).¹⁴⁰ The GMC, in its self-regulation model, was free to make clinical judgements but relied upon its medical members for guidance. The main medical expertise in the drugs field was represented by one of the most powerful London psychiatrists, Dr Philip Connell, who was a particular critic of private prescribing and a member of the GMC and its Executive Committee.

Describing her experience of visits from Chief and Senior Inspectors Bing Spear and John Lawson, Ann Dally recalled, 'I learned far more from them than from so-called specialists or from the medical literature. I tried not to say this to them because it embarrassed them. They were not supposed to be regarded as "medical experts"'.¹⁴¹ Spear in particular was one of the most knowledgeable individuals about the 'drug scene' and prescribing during his time at the Home Office,^{142, 143, 144}

¹³³ Home Office Drugs Inspectorate, 'Irresponsible prescribing enquiries: Investigation, preparation and presentation of evidence', (1983), Private archive.

¹³⁴ Home Office Inspector, (2002) *op. cit.*

¹³⁵ GMC, Professional Conduct Committee, Day Three, (8th March 1984), Case of Tarnesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. p.17.

¹³⁶ Home Office Inspector, (2002) *op. cit.*

¹³⁷ Medical Working Group on Drug Dependence, *Guidelines of Good Practice in the Treatment of Drug Misuse* (London: DHSS, 1984).

¹³⁸ Department of Health, Scottish Office Home and Health Department and Welsh Office, *Drug Misuse and Dependence. Guidelines on Clinical Management* (London: HMSO, 1991)

¹³⁹ UK Health Departments, *Drug Misuse and Dependence. Guidelines on Clinical Management* (London: The Stationery Office, 1999).

¹⁴⁰ eg. T. Bewley and A. H. Ghodse, 'Unacceptable face of private practice: prescription of controlled drugs to addicts', *British Medical Journal*, 286 (1983), 1876-1877.

¹⁴¹ A. Dally, (1990) *op. cit.*, p.134.

¹⁴² T. H. Bewley, Interview by Sarah Mars (2001).

¹⁴³ A. Dally, (1990) *op. cit.*, p.72.

¹⁴⁴ D. Turner [SCODA], Interview by Sarah Mars, (2002).

Advising doctors involved an intricate dance for the Inspectorate, unable to tell clinicians how to treat their patients, using professional peer opinion to justify their advice and yet holding over prescribers the threat of judging their behaviour. Here, Donald McIntosh, an inspector visiting Ann Dally in December 1985, advised her that a former patient from the North of England should, if he needed further treatment, receive it locally and not from Dr Dally. This was the exchange noted,

AD. *"I would be reluctant to take him back if you disapprove."*

DM. *"It is not for us to approve or disapprove. You could be criticised by your medical colleagues..."*¹⁴⁵

Inspectors had to give the appearance of not dictating acceptable treatments to a doctor, yet it was the Inspectorate who would refer cases to a Tribunal. The Tribunal itself was medical in membership, but the evidence would be supplied by the Inspectorate. The medical profession therefore retained an overarching power over the Inspectorate's regulatory authority, and each was dependent on the other to achieve a disciplinary result.

The publication of the first clinical guidelines by the Department of Health's Medical Working Group in 1984,¹⁴⁶ assisted the Inspectorate by providing further official medical support, but did not fundamentally change their approach. The Inspectorate had their own internal view on prescribing before the good practice guidelines appeared. These new guidelines drawn up by the Medical Working Group were used by the Inspectorate to increase its leverage in enforcing its existing views when visiting prescribers,¹⁴⁷ rather than accepting the views of the most influential addiction psychiatrists wholesale. One inspector commented, 'Once we had some guidelines we could actually point to something, say "You should do this, you should do that, your colleagues said all that..."'¹⁴⁸

The Inspectorate's own internal guidelines, which were drawn up in the early 1980s,¹⁴⁹ dealt mostly with pragmatic procedural matters, but included an appendix which showed what inspectors were looking for. The thrust of the questions, such as 'What steps did the doctor take to satisfy himself that the patient was addicted?' aimed at finding out whether a doctor was willing to prescribe drugs regardless of the patient's condition, and so potentially act as a supplier of drugs for non-medical

¹⁴⁵ GMC, Professional Conduct Committee, Day One, (9th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.1/50.

¹⁴⁶ Medical Working Group on Drug Dependence, (1984) *op. cit.*

¹⁴⁷ Senior Civil Servant, DHSS, Interview by Sarah Mars, (2001).

¹⁴⁸ Home Office Inspector, (2002) *op. cit.*

¹⁴⁹ Home Office Drugs Inspectorate, (1983) *op. cit.*

reasons is not in the treatment of addiction. A check-list of practices indicative of appropriate or inappropriate prescribing was set out as follows:

a Physical examination? – complete or merely arms?

b Blood/urine tests?

c Observance of withdrawal symptoms?

d Observance of self-administration?

e Checks with previous doctors/contacts?

f Proof of the addict's claimed identity?

g Notification? and response to information provided by the Addicts Index?

h Any additional checks in respect of patients from outside his area?

*i Was a prescription issued before or not until the results of these checks were known?*¹⁵⁰

These criteria did not seem aimed at imposing a single model of treatment, as the 1984 good practice guidelines did, and the document seemed to bear out its claim that the purpose of investigations was 'not to stop a doctor from prescribing controlled drugs to addicts if that is being done in a controlled and responsible manner, nor to force him to conform to a particular treatment regime although advice about consensus trends in treatment may be offered in conjunction with the names and locations of specialist treatment facilities.'¹⁵¹

This mention of 'consensus' was rather surprising, as it was clearly lacking in the medical profession at that time. In 1986, the Home Office was clearer about different approaches, when discussing Tribunals. In Peter Spurgeon's first Annual Report, after taking over from Bing Spear as Chief Inspector, he wrote:

*Neither the pursuit of individual cases, nor the Home Office policy underlying the Inspectorate's general approach is coloured by one medical school of thought or another on prescribing philosophy, which remains a highly variable commodity ranging from strict non-prescribing of substitutes in some areas through to open acceptance of long-term maintenance prescription as a last resort in others. Our basic concern is quite simply to ensure as far as is practicable and reasonable that the styles adopted by medical practitioners in their treatment of drug misusers are consistent with the need to prevent significant leakage of controlled drugs into the illicit market.'*¹⁵²

¹⁵⁰ *Ibid.*

¹⁵¹ *Ibid.*

¹⁵² Drugs Branch Inspectorate, *Annual Report 1986* (London: Home Office, 1987), Ref. 49910, DrugScope Library, London.

The extent to which the Inspectorate expressed views independent of the Clinic treatment orthodoxy varied over the period. The early to mid-1970s was a time of experimentation in the Clinics, with relatively little concern about private prescribing.¹⁵³ As lines of allegiance hardened, Spear stood out against the methadone and short-term detoxification model held up by the Clinic leaders of the late 1970s and 1980s, but according to his successor, Peter Spurgeon, he was only able to do this because of the special respect he had built up within the policy community, and the length of his service, joining the Inspectorate in 1952 long before the Clinics were established.¹⁵⁴

In 1985 and '86 Spear was absent from the Inspectorate for long periods due to illness, and newly appointed Senior Inspector for the South East Region, Donald McIntosh, who had moved from the Bradford office, acted in his place. He took a key role in advancing regulatory action against Ann Dally and at her GMC hearing reported asking her, 'Does not long-term prescribing give a soft option to carry on taking drugs?',¹⁵⁵ and suggesting that the fact that her patients were unwilling to go to their local NHS Clinics indicated that they were only coming to her for a supply of drugs. His questions seemed to reveal a view that prescribing was 'perpetuating' patients' 'addiction and problems'.¹⁵⁶

By the 1990s, the Inspectorate's enforcement policies took into account the longer term prescribing patterns that had emerged from the harm reduction movement following HIV/AIDS.¹⁵⁷ However, in some respects they could be said to have reflected the aims of the London Clinics, many of which, although influenced by harm reduction, remained resistant to the idea of long term prescribing.¹⁵⁸ Despite the apparent widespread acceptance of oral methadone maintenance during the 1990s, the overall aim of reducing patients' prescribed doses continued to appear in criticisms of doctors, as in the Tribunal's charges against Dr Adrian Garfoot in 1994, which included prescription 'without instituting a reducing regime' and prescribing not according to the (1991)

¹⁵³ eg Thomas Bewley, who became one of the fiercest opponents of private prescribing, only mentioned GPs, not private prescribers, as a source of diverted pharmaceuticals in his 1975 article: T. Bewley, 'The Illicit Drug Scene', *British Medical Journal*, 2 (1975), 318-320.

¹⁵⁴ P. Spurgeon, (2004) *op. cit.*

¹⁵⁵ GMC, Professional Conduct Committee, Day One, (9th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.1/45.

¹⁵⁶ *Ibid.* p.1/45.

¹⁵⁷ A. Macfarlane, (2002) *op. cit.*

¹⁵⁸ H Hudebine, 'Applying cognitive policy analysis to the drug issue: harm reduction and the reversal of the deviantization of drug users in Britain 1985-2000', *Addiction Research and Theory* (forthcoming).

clinical guidelines. A further charge was that he had not consulted 'experts in the treatment of drug misuse, such as a local drug dependency unit'.¹⁵⁹

Leadership of the Inspectorate

Charles Jeffrey (Chief from at least 1970 until 1977)

Charles Jeffrey left few accessible documentary sources for the historian to assess his contribution, but seems to have taken a personal approach to the welfare of addicts that has often been credited to Spear alone. Ken Leech, community theologian at St Botolph's, Aldgate, and active with drug users since the 1960s, mentioned that drug users often invited themselves to tea at the Home Office under Jeffrey's leadership and an inspector of the Royal Pharmaceutical Society remembered Jeffrey as a very sociable man.^{160,161} For many, though, his memory seems to have been overshadowed by the more charismatic figure of Spear.^{162,163}

From Spear's references to Jeffrey, they sounded of a similar mould. For instance, he reported a meeting with the Ministry of Health and medical representatives at which an important remark was made either by Jeffrey or himself, but he was unable to remember which.¹⁶⁴ However, this may simply have been Spear's tendency to portray civil servants as pursuing the policy of the Inspectorate, rather than bringing distinct personalities to their work.

H.B. ('Bing') Spear (Chief 1977-1986)

Spear joined the Home Office Drugs Inspectorate in 1952 and became its Chief in 1977 until ill health forced him to retire in 1986. Spear was perhaps the most celebrated civil servant in the drugs field during the twentieth century. His book, *Heroin: Addiction Care and Control*, published posthumously, was prefaced with warm appreciations, and he was remarkable in his ability to gain the trust and respect of fiercely divided parties in the treatment and control arenas.^{165,166,167} His personal concern for addicts, and encouragement of doctors to take on their care, including those in the private sector, showed an interest beyond the mechanics of regulating the drug supply.

¹⁵⁹ *In the Matter of the Misuse of Drugs Act 1971 and In the Matter of Dr John Adrian Garfoot. Minutes of Proceedings at a Misuse of Drugs Tribunal (England and Wales)*, (22nd June 1994), W. B. Gurney and Sons [transcript], GMC Archive, London, p.10.

¹⁶⁰ K. Leech, 'Bing Spear: Appreciations', in H. B. Spear (2002) *op. cit.*, pp.ix-xi.

¹⁶¹ G. E. Appelbe, (2004) *op. cit.*

¹⁶² eg. M. Mitcheson, Interview by Sarah Mars, (2003).

¹⁶³ eg. J. Mott, Personal Communication, (2005).

¹⁶⁴ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.156.

¹⁶⁵ eg. T. Bewley, (2001) *op. cit.*

¹⁶⁶ eg. A. Dally, (1990) *op. cit.*, p.72.

¹⁶⁷ eg. D. Turner, (2002) *op. cit.*

In his last couple of years at the Inspectorate, Donald McIntosh's stricter and less permissive attitude towards private doctors, including those, such as Ann Dally, who had previously been visited by Inspectors on a 'friendly' basis, dominated.¹⁶⁸ Dally considered that it was Spear's frequent absences in hospital which 'gave an opportunity to harder and more traditional bureaucrats',¹⁶⁹ but others saw McIntosh as Spear's preferred successor.¹⁷⁰

Spear complained that the Clinic psychiatrists had 'succeeded in imposing their own ethical and judgemental values on treatment policy',¹⁷¹ but he himself was far from morally or politically neutral. From his position in the Inspectorate he was able to sway government policy to modify the influence of the Clinics and he attempted to diversify prescribing and treatment provision for drug users, while retaining and in some cases strengthening the Home Office's own regulatory mechanisms.

Peter Spurgeon, Chief Inspector 1986-89

Spurgeon followed Spear as Chief Inspector from 1986, moving straight into the post from criminal policy work within the Home Office. Spurgeon was keenly aware of the respect in which Spear was held both within and outside the Inspectorate and his annual reports suggested a similar approach to his predecessor.^{172,173,174} It is not certain why Spurgeon rather than McIntosh got the chief post but the former attributed his appointment from a managerial post outside the Inspectorate, rather than the promotion of an internal candidate, to the tendency towards a more managerial approach across government in the mid-1980s.¹⁷⁵

Certainly his appointment does not seem to have been an attempt to alter the political direction of the Inspectorate. Spear was sympathetic towards drug users, highly critical of the enforcement dominated US approach, and wary of claims for what could be achieved through policy as 'sooner or later society will have to reach an accommodation with drug use'.¹⁷⁶ Spurgeon's attitudes largely

¹⁶⁸ Home Office Inspector, (2002) *op. cit.*

¹⁶⁹ A. Dally, (1990) *op. cit.*

¹⁷⁰ J. Mott, (16th March 2005) *op. cit.*

¹⁷¹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.310.

¹⁷² P. Spurgeon, (2004) *op. cit.*

¹⁷³ Home Office Drugs Branch Inspectorate, *Annual Report 1987* (London: Home Office, 1988), Ref. 52150, DrugScope Library, London.

¹⁷⁴ *Ibid.*

¹⁷⁵ P. Spurgeon, (2004) *op. cit.*

¹⁷⁶ Home Office Drugs Branch Inspectorate, (1986) *op. cit.*, p.21.

matched these. He had a historical sense of his place within the traditions of the Inspectorate and was happy to follow Spear's 'compassionate approach to the problem'.^{177,178}

Alan Macfarlane (1990 to the present)

When Macfarlane took over as Chief Inspector, like his predecessor Spurgeon, he was a career civil servant with no previous experience in the Inspectorate. His approach to prescribing differed sharply from that of Bing Spear's. He was highly critical of private prescribers, the majority of whom he considered 'wicked',¹⁷⁹ and unsympathetic towards the views of drug users themselves.¹⁸⁰ At the end of the century, drug users were organising into activist groups that were beginning to receive recognition from charities and local government,^{181,182} but under Macfarlane the Inspectorate took a hostile view to the participation of such groups in the policy process.¹⁸³

The success of Dr Adrian Garfoot's appeal against the Tribunal's ruling was a serious blow to Macfarlane, after a lengthy and expensive process for the Home Office. It signalled the end of the Tribunal system, which had also emerged as contravening Human Rights Legislation.¹⁸⁴

Macfarlane had chosen the wrong private prescriber to pursue in Adrian Garfoot, whose heavy weight defence fought a far harder battle than anticipated by the Home Office prosecution who were used to easy, uncontested admissions from the accused.¹⁸⁵

Macfarlane had hoped to extend the Home Office's licensing scheme for doctors prescribing certain controlled drugs but despite recommendations in favour from the Department of Health's Clinical Guidelines Working Group, the necessary legislation was not passed and the protesting GPs won out (see Chapter 7). Under Macfarlane's leadership the Inspectorate lost two important regulatory tools: the Addicts Index and the Tribunal system, while suffering diminishing influence over policy.

¹⁷⁷ See, for instance, historical introduction to P. Spurgeon, 'Crack and other drugs – myth or menace?' *Looking Ahead 1989 Conference Report* (Swindon: Swindon Crime Concern, 1989) pp.3-4.

¹⁷⁸ P. Spurgeon, (2004) *op. cit.*

¹⁷⁹ A. Macfarlane, (2002) *op. cit.*

¹⁸⁰ *Ibid.*

¹⁸¹ UK Charity Worker, Interview by Sarah Mars, (2002).

¹⁸² S. L. Hayward, Interview by Sarah Mars, (2003).

¹⁸³ Senior Civil Servant, Home Office, Interview by Sarah Mars, (2002).

¹⁸⁴ Home Office, *Guidance to Chemist Inspecting Officers*, (Home Office, London: 2002), Document WM 17 00388.

¹⁸⁵ The Shipman Inquiry, www.theshipmaninquiry.org.uk.

¹⁸⁶ A. Macfarlane, (2002) *op. cit.*

Motives for Regulation

Although the Inspectorate's mission was the prevention of drugs being diverted from the authorised channels throughout this period,¹⁸⁶ it pursued additional policy goals and priorities, being guided by its changing internal views on the needs of patients, appropriate treatment and the doctors who provided it. For instance, Inspector John Lawson, on his visit to Dr Tamesby's practice in December 1981, claimed to have advised him that prescribing *Dional* to drug users could be dangerous as it this oral tablet was often hazardously crushed and injected.¹⁸⁷ Here, concern about the health of patients, as well as the destination of prescribed drugs, influenced regulation. A number of sources also showed that the Home Office placed emphasis on the motivations of drug doctors, rather than simply the type of prescribing they were undertaking, suggesting an interest in the care given to addicts going beyond their remit of controlling diversion, and a degree of moral judgement.

Charles Jeffrey, writing in 1970, referred to two types of drug doctors on the scene a decade earlier: 'script doctors' and a new kind of 'dedicated practitioners' whose motives were 'unimpeachable', although despite their different motivations, Jeffrey attributed to both the overflow of drugs onto the black market.¹⁸⁸ Spear maintained this distinction,¹⁸⁹ and according to an inspector with 20 years' experience, Spear directed the powers of the Inspectorate accordingly:

*'I think Dally was there to help people in the same way that Garfoot was there. They were a bit misguided, but that was what they were doing. Whereas [X] and [Y] were just evil men... They were different type of people... [X] and [Y] were being taken before Tribunal – a bit evil and in it for the money. There were other doctors prescribing to addicts who were seen on a regular basis but more in a friendly advisory way and Dally was one of these. She was encouraged to get involved by Bing.'*¹⁹⁰

Although a Tribunal was brought against Dr Garfoot, it was after many years of advice and 13 oral and written warnings given between 1982 and 1992,¹⁹¹ and with Dr Dally, although a Tribunal was threatened in 1986, seven years after she accepted her first drug addict patient, it was never brought. Dr Tamesby, cast as motivated by greed, by contrast, was served with Tribunal papers in 1983 only

¹⁸⁶ J. Scullion, (27th June 2003) *op. cit.*

¹⁸⁷ GMC, Professional Conduct Committee, Day Three, (8th March 1984), Case of Tamesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. pp.12-15.

¹⁸⁸ C. G. Jeffrey, 'Drug control in the United Kingdom', in R. V. Phillipson (ed.), *Modern Trends in Drug Dependence and Alcoholism* (London: Butterworths, 1970) pp.60-74, p.67.

¹⁸⁹ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.42-62.

¹⁹⁰ Home Office Inspector, (2002) *op. cit.*

¹⁹¹ Home Office, Report of a Tribunal Set Up Under the Misuse of Drugs Act 1971 to enquire into the Conduct of Dr John Adrian Garfoot MB BS MRCS LRCP, 1994, (Dr Garfoot, Private archive) pp.4-5.

a year and a half after his first addiction prescribing. Theoretically, this also applied with the GMC, where 'bona fide' intention was considered in prescribing, but in practice, good intentions, even where proven as far as they could be, could be disregarded, as occurred in Dr Dally's two GMC cases (see Chapter 5).

In addition to direct regulation, visits by the Inspectorate had an intelligence gathering role, at least during the 1980s. Spear remarked,

*Not all visits to practitioners...are in respect of some offences or irresponsible prescribing. There are a few general practitioners who are taking a particularly keen interest in drug misuse problems and who welcome periodical visits from the Inspectorate. In turn much valuable information about the local drug scene is obtained from these practitioners.*¹⁹²

Of course, a doctor at one time considered in this intelligence giving capacity, like Ann Dally, could become one of the regulated under a change of leadership.

Although the Inspectorate directed the practice of doctors towards controlling the drug supply, it could also be seen as having a training role for practitioners new to the field in a dearth of other sources. *Treatment and Rehabilitation* (1982) remarked on the lack of training opportunities for doctors faced with addicted patients.¹⁹³ During the 1970s and '80s there was very little time spent on addiction in the undergraduate medical curriculum and little opportunity for training for postgraduates other than psychiatrists specialising in addiction. Testifying before the Social Services Select Committee in 1985, Dr Stuart Carne, Senior Tutor in General Practice at the Royal Postgraduate Medical School, agreed that the basic general practitioner training was not sufficient for a GP to be able to recognise an addict. Dr John Cohen, a GP member of the first Guidelines Committee and a Senior Lecturer in General Practice at Middlesex Hospital Medical School, considered there were insufficient experienced psychiatrists in drugs to provide a network for training.¹⁹⁴

Some doctors starting to treat drug users had minimal knowledge of treatment modalities, and the Inspectorate could be the most knowledgeable sources available to them. Dr Tarnesby, for

¹⁹² Home Office Drugs Branch Inspectorate, (1986) *op. cit.*, p.12.

¹⁹³ ACMD, (1982) *op. cit.*, p.63.

¹⁹⁴ House of Commons, Minutes of Evidence Taken before the Social Services Committee, (6th February 1985), *Misuse of Drugs with Special Reference to the Treatment and Rehabilitation of Misusers of Hard Drugs. Fourth Report from the Social Services Committee Session 1984-85* (London: HMSO, 1985) pp.14-21.

instance, learnt about prescribing methadone and *Diconal* during his first visit from an inspector in December 1981, before which he was unaware that he could prescribe them, and Dr Dally commented on how much more she had learnt from the inspectors than from medical 'experts'.¹⁹⁵

Effects of Regulation on the Treatment of Addiction

While the Clinics were largely left by the Inspectorate to self-regulate, a critical effect of the Home Office's activities on doctors treating drug users outside the DDUs was to extend and delegate policing of the drug supply from the Home Office to doctors themselves working outside the Clinics, with penalties for not doing so. The GMC case against Dr Tarnesby, at which the Inspectorate gave evidence for the prosecution, showed a range of issues doctors were supposed to be aware of to maintain control over the drugs supply, aside from and sometimes in potential conflict with the doctor's own perceptions of the patients' needs. For instance the patient should be of known provenance, with a referral from a GP or other doctor. Spear wrote to Tarnesby reminding him of

*the need for extreme caution in prescribing for patients previously unknown to the practice who claim, but cannot readily confirm, that they have been in regular receipt of controlled drugs. As you no doubt appreciate from your recent experience, a doctor who is prepared to accept such patients may soon find himself inundated by similar requests and may well unwittingly become an important source of drugs circulating in the illicit market.*¹⁹⁶

Tarnesby, although clearly trying to make a good account of himself under cross-examination before the GMC, described the change in his practice resulting from this regulatory attention:

*...when there was a GP I did enquire and the difficulty about it is when the patient states he does not have a GP, and I then thought if he has not got a GP and he says he has never attended anybody for treatment what can I do? But nowadays I would say: "Then in that case I will not accept him." Indeed, if now I were faced with that same choice I would say: "Well, it is just too bad. I cannot accept him", but at that time I felt I must bend over backwards to accept him, and that, I think, can lead to undesirable results, and I would not do it again.*¹⁹⁷

Whether this was accurate or not, it indicated the direction of the pressures on these doctors. On the question of patients losing their jobs once in treatment, Mr McIntosh, when giving evidence

¹⁹⁵ A. Dally, (1990) *op. cit.*, p.134.

¹⁹⁶ H. B. Spear, Letter to H. P. Tarnesby, (17th June 1982), quoted in GMC, Professional Conduct Committee. Day Three, (8th March 1984), Case of Tarnesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. p.20.

¹⁹⁷ GMC, Professional Conduct Committee. Day Four, (9th March 1984) Case of Tarnesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. p.77.

against Ann Dally, explained 'it was incumbent upon her to make the most stringent continuous inquiries to satisfy herself that this person had a legitimate means of meeting the costs without resort to some criminal activities'. And although not explicit, it seemed expected that a private prescriber should discharge any patient found to have lost their job.¹⁹⁸ Tarnesby claimed that most of his patients owed money but were still seen.¹⁹⁹ Doctors were also discouraged from accepting patients outside the locality of their practice, as the Inspectorate were concerned about the geographical spread of patients, not as a treatment or medical issue, but one concerning the market in diverted drugs. John Lawson, an Inspector giving evidence at Tarnesby's GMC hearing, stated, 'Most doctors who prescribe for addicts tend to attract addicts from their own area. Once a doctor starts to attract addicts from other parts, the whole of London, or the Home Counties, we become suspicious that he is a "soft touch"'.²⁰⁰ The Inspectorate was also concerned that, through 'long-distance prescribing' markets in diverted prescribed drugs could develop in areas outside London that had been previously unaffected.²⁰¹

An unexpected role of the Inspectorate was in finding doctors for patients who were in difficulties, including those of doctors who had been disciplined and were no longer able to prescribe. The Home Office directed Dr Dally's patients to both an NHS Clinic and another private prescriber after her second case.²⁰² According to Peter Spurgeon, this function was a result of 'the relationship with the drug using community built up by Bing Spear', but may have preceded his tenure. The criteria for choosing these doctors for referrals were, according to Spurgeon, who could not be seen to show preference for particular treatment modalities, 'logistics and practicalities' rather than treatment modalities.²⁰⁴

Other Regulatory Pressures

When visiting doctors, the Inspectorate not only expressed its own concerns, but also made them aware of the interests of the press, particularly the tabloids, in their practices. In this, the popular press acted as an additional regulatory pressure upon doctors, particularly those in private practice, who constituted targets for negative publicity in the 1980s and '90s, and a potential source of information to the Inspectorate and GMC.

¹⁹⁸ GMC, Professional Conduct Committee, Day One, (9th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. p.1/85.

¹⁹⁹ GMC, Professional Conduct Committee. Day Four, (9th March 1984) Case of Tarnesby, Herman Peter, T A Reed & Co. [transcript], GMC Archive, London. p.48.

²⁰⁰ GMC, Professional Conduct Committee. Day Three, (8th March 1984), Case of Tarnesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. p.17.

²⁰¹ Home Office Inspector, (2002) *op. cit.*

²⁰² A. Dally, Interview by Sarah Mars, (2002).

²⁰³ C. Brewer, Interview by Sarah Mars, (2000).

²⁰⁴ P. Spurgeon, (2004) *op. cit.*

Inspector John Lawson reported that in a conversation in December 1981 'I mentioned to Dr Tamesby in my experience he would have to be careful when dealing with addicts because the press once they became aware a doctor is dealing with addicts can see headlines and they are apt to put in reporters claiming to be addicts.'²⁵ Despite this warning Dr Tamesby was hoodwinked by a *Daily Mirror* reporter posing as a drug dependent patient to whom he prescribed. After this Tamesby claimed to have instituted greater checks such as physical examinations of the patient to check for signs of injecting, and 'I decided I will never use self-injectables again, and never did',²⁶ although this latter claim was disputed by another inspector.²⁷

Alerted by the reporter's article,²⁸ the Inspectorate interviewed Dr Tamesby after the journalists' accusatory article appeared in the *Daily Mirror*, but were satisfied with his answers and did not pursue the matter further.²⁹ In Tamesby's GMC hearing it was not made explicit why this was the case, but cross-examination of the Home Office Inspector and the reporter suggested that some aspects of the newspaper's account might have been fabricated.³⁰

Theoretical Interpretations

From a more theoretical perspective, the workings of the Inspectorate can be seen as those of a bureaucracy. Max Weber's influential work described the basis of bureaucratic power as technical expertise and knowledge developed through experience in the service, clearly characteristics of this Inspectorate. He also saw bureaucracies as having an interest in perpetuating themselves into permanent institutions, rather than serving the ends for which they were originally designed.³¹ This too can be seen in the Drugs Inspectorate, which developed into a source of policy advice for government, training for prescribers, an occasional referral agency for patients, and policy actor in its own right.

Similar processes were also observed by Rhodes in his wider examination of inspectorates within British government, which often did more than their original task of inspecting. Rhodes found that other central government inspectorates, as well as enforcing legislation among those they inspected,

²⁵ GMC, Professional Conduct Committee. Day Four, (9th March 1984) Case of Tamesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. p.78.

²⁶ *Ibid.* p.27.

²⁷ Home Office Inspector, (2002) *op. cit.*

²⁸ J. Merritt, 'Doctors who trade in misery', *Daily Mirror*, (18th February 1982), 7-8.

²⁹ GMC, Professional Conduct Committee. Day Three, (8th March 1984), Case of Tamesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. p.3.

³⁰ GMC, Professional Conduct Committee, Day Two, (7th March 1984), Case of Tamesby, Herman Peter, T. A. Reed & Co. [transcript], GMC Archive, London. pp.39-91.

³¹ M. Weber, (1964) *op. cit.*, pp.228-240.

had developed into professional advisors to ministers and departments.²¹² He saw inspectorates as not only enforcing standards, but setting them too, which also matched the Home Office case and similarly he found division made by the inspectors between those they inspected on a friendly basis, who were considered reputable, and the dishonest who were prosecuted.

The act of surveillance has received particular attention in the history of medicine and beyond since Michel Foucault's ideas on the place of the body in modern medicine and on 'disciplinary power' became influential.^{213,214} However, the impersonal nature of Foucault's surveillance did not fit the very individual imprint left by the Inspectorate's changing leadership or the personal relationships between observer and observed. Furthermore Foucault's denial of personal agency as a historical force has been hard to square with this picture.

However, Foucault did not necessarily intend his ideas to be taken as a general or consistent theory, or to be applied to other historical contexts.²¹⁵ His followers were more imperialist in their claims, and some of their work may inform this one. David Armstrong's expansion on Foucault's ideas to medical surveillance in the twentieth century has provided an interesting comparison. He described the archetype of a tuberculosis 'Dispensary' which acted as a central clearing house for information about sickness and potential sickness in the wider community, mapping the spread of disease and gaining the consent of the well population to undergo policing and surveillance.²¹⁶ This contrasted with the institutionalised surveillance of prisons and schools in that it looked into the spaces between bodies in their community environments creating a new concept of social space taking groups of people to be the reservoirs of disease.

The infectious disease model of drug addiction that was overtly expressed to justify the compulsory notification requirements for the Addicts Index, a key tool for the Inspectorate's surveillance of doctors and patients, showed clear parallels to Armstrong's Dispensary. Like the Dispensary, the Inspectorate was a central clearing house for information and intervention among the community, in this case one made up of doctors and drug users, with varying degrees of consent. The

²¹² G. Rhodes, (1981) *op. cit.*, p.171.

²¹³ Foucault, M. *The Birth of the Clinic: An Archaeology of Medical Perception*, translated by A. M. Sheridan Smith (first published 1963, Presses Universitaires de France, this edition, New York: Vintage Books, 1994).

²¹⁴ Foucault, M. *Discipline and Punish: The Birth of the Prison*, translated by A. Sheridan (first published 1975, Edition Gallimard; this edition Harmondsworth, England: Penguin Books, 1991) pp.257-292.

²¹⁵ F. Driver, 'Bodies in space: Foucault's account of disciplinary power' in C. Jones and R. Porter (eds.), *Rethinking Foucault: Power, Medicine and the Body* (London and New York: Routledge, 1998, first published 1994) pp.113-131.

²¹⁶ D. Armstrong, *Political Anatomy of the Body: Medical Knowledge in the Twentieth Century* (Cambridge: Cambridge University Press, 1983) pp.7-18.

movement of drugs, which could equate with agents of infection in the communicable disease model of the second Brain Committee, between patients and other drug users, had taken the place of the tuberculosis bacilli. However, although Armstrong's model of the Dispensary may have illuminated the development of social space in infectious disease, it has not substantially added to our understanding of the Home Office Inspectorate or the Addicts Index, the roles of which were openly declared to be part of a public health system of control of drug addiction in which health care and disciplinary processes were combined.

Conclusion

Throughout the last three decades of the twentieth century, the Inspectorate's regulatory gaze fell on the doctors working outside the Clinics, despite evidence that drugs leaked also from the Clinics onto the illicit market.²¹⁷ While the Clinics' leaders united successfully to largely self-regulate, private prescribers failed, and GPs, although starting off weakly, by the end of the century appeared to be fending off further state regulation through their Royal College.

The regulatory tools available to the Inspectorate, and their use, passed through several different phases over the period: 1970-73 was a period of frustration; the Tribunal system had passed into legislation in 1971 but was awaiting the 'on' switch to be flicked, with a GMC reluctant to take action itself; from 1973 to '82 the Tribunal system was used, but only occasionally, probably due to unwillingness by Home Office lawyers to accuse doctors of irresponsible prescribing, while the GMC took some action itself.²¹⁸ After 1982, the GMC continued to discipline private prescribers and the use of Tribunals became more frequent until the mid-1990s Garfoot 'watershed'. Garfoot's was the last Tribunal, initiated in 1993, and finally overturned on appeal in 1997, from which point on Tribunals fell into disuse, partly as a result of supra-national regulation, followed by the Inspectorate shrinking its work with doctors and the GMC taking over as sole prosecutor of 'irresponsible' prescribers, gathering momentum at the turn of the century. Although the Inspectorate and the GMC continued to co-operate, with the Inspectorate providing some of the information used for the GMC cases, the weight was on professional rather than state regulation.

Until the mid-1980s the Inspectorate, like some other central government inspectorates, played a key role within the policy community, both in advising ministers and other policy bodies such as the ACMD, and also by supporting and protecting doctors who differed in philosophy from the London Clinics where they were judged to be well-motivated. Under Spear, the Inspectorate

²¹⁷ A. Burr, 'The Piccadilly drug scene', *British Journal of Addiction*, 78, 1 (1983), 5-19.

²¹⁸ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.63.

worked to maintain diversity in treatment services by opposing the extension of licensing in the mid-1980s (see Chapter 4). Bing Spear was particularly influential because of his own highly respected knowledge, personal charisma, perceived neutrality and because of the narrower policy community of his time. Spear fostered the internal expertise of the Inspectorate, mostly using medical advice to support and legitimise existing lay-developed policy, rather than relying upon them for direction.

Once Spear had gone, there appeared to be an opportunity for the Clinics to strengthen their position and curtail the prescribing of other doctors. After manoeuvres against private prescribers initiated by McIntosh, policy was pushed in the opposite direction by events outside the Inspectorate. The emergence of a near consensus for harm reduction treatment policies which developed after HIV/AIDS became a policy issue, and the diversification of the policy community to include more non-medical influences weakened claims of the Clinics to be the sole source of expertise and gave opportunities to those pursuing a more liberal prescribing policy outside the Clinics.

During the 1990s the Inspectorate's leadership sought greater control over non-Clinic prescribers, but failed to protect its sources of strength, losing two regulatory mechanisms: the Addicts Index and the Tribunal system. By the end of the twentieth century, the Inspectorate was a much diminished force. After an initially heightened status as the main advisory source of ministers, it had failed to capitalise on the growing political importance of the drugs issue, losing out to other more specialised agencies and cost-cutting exercises. Other developments such as the government and media pressure on the GMC to increase its regulatory activity across all of medicine, and the questioning of doctors' ability to self-regulate, in addition to the costly failure of the Garfoot case and the end to Tribunals, left the Inspectorate dependent upon the GMC to enforce the findings of its much reduced inspections.

One source of pressure surprisingly absent from the Inspectorate was that of public opinion. The Inspectorate was noteworthy in its low public profile, rarely heard of outside the drugs field. This meant that, unlike some of the inspectorates considered by Rhodes, public opinion had little influence on its policing priorities. Drug policy in the 1960s and 70s had been largely determined behind closed doors between civil servants and members of the policy community. From the mid-1980s, public opinion and political interest had a little more influence although in a scattered and inconsistent fashion, but the priorities of the Inspectorate continued to reflect its own internal views and elements of the policy community until the end of the century.

Throughout these three decades, the Inspectorate informally cooperated with the other strands in the regulatory network, both state and professional, to gather intelligence, and to advise and discipline those non-Clinic doctors it found wanting. To influence policy according to its own agenda, the Inspectorate made strategic alliances with medical professionals, other government departments and policy bodies, with varying degrees of success.

Chapter 7

Major Regulatory Interventions III: 1999 Guidelines and the Licensing Question

Introduction

After a long and somewhat troubled delivery, the third edition of the clinical guidelines on drug misuse – the 'Orange Book' – emerged into the world in April 1999.^{1,2} Following on from the first edition in 1984 and its 1991 revision, this was a substantial piece of work: it was the biggest, the most heavily referenced, with the longest production period and the largest Working Party.

The 1984 Guidelines were considered in detail in Chapter 4. A conservative revision was made of them published in 1991, but the text retained much of its first edition. Some small concessions were made to 'harm reduction', for instance giving advice for patients on cleaning syringes with bleach in the absence of sterile replacements, but major change did not happen until the late 1990s.³ Furthermore, it was only the first and third guidelines working groups that considered the extension of licensing that had particular implications for private prescribers.

The '99 Guidelines repeated concerns that dated back to the policy changes of the late 1960s and also reflected the changed treatment environment of the late 1990s. Past continuities could be seen in the attempt to regulate prescribing by private doctors and NHS general practitioners, particularly with regard to scripts for injectable and other opioids. This chapter addresses these developments in two parts: the '99 Guidelines themselves and the licensing proposals that accompanied them. Before considering them, however, some understanding of the background is needed.

Developments in health service policies

The major changes from the previous two versions of the guidelines reflected wider political changes, developments in the country's drug misuse, in treatment policies and services, and in the nature of clinical guidelines themselves. These included the relentlessly increasing scale of UK drug

¹ UK Health Departments, *Drug Misuse and Dependence: Guidelines on Clinical Management*, (London: The Stationery Office, 1999).

² Department of Health, 'Government to improve care for drug misusers – New Guidelines for Doctors', Press release reference 1999/0220, (12th April 1999), www.dh.gov.uk.

³ Department of Health, Scottish Office Home and Health Department and Welsh Office, *Drug Misuse and Dependence: Guidelines on Clinical Management*, (London: HMSO, 1991).

use; expansion of treatment services trying to meet the rise in patient demand; the increasing participation of GPs and non-medical professionals in treating drug misuse; the Department of Health's more developed role in treatment policy; the emergence of HIV and the policy responses around it, particularly the new international orthodoxy of methadone maintenance; the policy aim of a 'primary care-led' National Health Service; changes in key policy personnel at the Home Office and Department of Health; the growth of services, expertise and drug use outside the traditional London centres; the cause of 'evidence-based medicine'; and a run of medical scandals resulting in calls for tighter regulation of the profession (see also Chapters 2 and 5). The third edition of the *99 Guidelines* grew out of a number of these changes.

1984-5 had seen the introduction of general management into the NHS and the overt encouragement of local decision-making. Paradoxically, the government saw this devolution as requiring extensive central co-ordination and encouragement through its provision of a multitude of guidelines, directives and circulars. This could be seen in the drugs field too a little earlier, where efforts to develop local services, often in the voluntary sector, through the Central Funding Initiative (1983-89), were orchestrated by Whitehall (see Chapter 2). As well as stimulating the voluntary sector, the government provided modest incentives for people to take up private health insurance and ended Labour's opposition to private beds in NHS hospitals. Over the 1980s, the number of private hospitals providing abstinence oriented treatment for drug dependent patients grew considerably.⁴

A boost to the trend for clinical guidelines came with the introduction of the internal market into the NHS from 1989. Without the levers of a true market, all kinds of government mechanisms were developed to try to make health care more measurable and comparable for contracting decisions between GP purchasers and hospital or community service providers. Questions about what constituted good quality care fuelled a new guidelines industry. Clinical audit, introduced in 1990 with generous Department of Health funding, was a new tool for measuring the outcomes of treatment, and for changing treatment where it was considered deficient. Doctors' leaders participated grudgingly and practitioners were obliged by government to do so.⁵ In order to define good treatment, guidelines were needed here too.

⁴ D. Curson, 'Private treatment of alcohol and drug problems in Britain', *British Journal of Addiction*, 86 (1991), 9-11.

⁵ The author worked for the British Medical Association's Clinical Audit Working Group in the early 1990s.

To meet this demand, academics and professional medical bodies developed expertise on the development of guidelines, encouraged by Department of Health funding.⁶ This, along with the movement for 'evidence based medicine', partially arising from the medical profession, led to greater formalisation of the production of guidelines and an insistence that they be based upon formal research studies. The evidence based medicine movement helped to legitimise the use of guidelines within the profession and although most elements of the internal market were dropped by the Labour government, the revival of managerialism as a driver of change found favour in their continued use.

In the 1990s, responsibility for guidelines became more corporate and statutory. New standards were set for clinical guidelines by the Department of Health's Clinical Outcomes Group, requiring greater formal use of research evidence and an external system of review. Previous guidelines, published prior to or in the early stages of the 'evidence-based medicine' movement, had made little reference to published research evidence: the 1984 *Guidelines*, probably the first official guidelines document in UK health services, contained no references to scientific studies, only reports, textbooks or reference sources such as the British National Formulary, while the 1991 edition referenced fewer than five research studies.^{7,8} The 1999 edition, by contrast, contained almost one hundred research references.⁹

Accompanying these changes came a number of moves that strengthened the position of GPs within the health service, such as fundholding that gave primary care doctors greater control over their budgets and enlarged their scope to provide additional services. Fundholding also changed the balance of power between hospital consultants and their GP customers.¹⁰ There were disincentives for GPs to send their patients to hospital, leading to primary care provision of services such as minor surgery, and the emergence of 'GP specialists', who had developed particular expertise in the treatment of a particular patient group or condition. For the treatment of chronic diseases, such as diabetes, GPs were encouraged to enter into 'shared care' arrangements with hospitals. These could follow a wide range of models, but the essential idea was that specialists and

⁶ For instance, the Royal College of Psychiatrists' College Research Unit, reliant mainly on outside project funding, received a number of grants from the Department of Health to develop clinical guidelines.

⁷ Medical Working Group on Drug Dependence, *Guidelines of Good Practice in the Treatment of Drug Misuse* (London: DHSS, 1984).

⁸ Department of Health, Scottish Office Home and Health Department and Welsh Office, *Drug Misuse and Dependence. Guidelines on Clinical Management* (London: HMSO, 1991).

⁹ UK Health Departments, *Drug Misuse and Dependence. Guidelines on Clinical Management* (London: The Stationery Office, 1999).

¹⁰ R. Klein, *The New Politics of the National Health Service* (first published 1983, London and New York: Longman; fourth edition, Harlow: Prentice Hall, 2001).

GPs would plan a patient's care together, explicitly sharing out various aspects of the work between them.¹¹

The development of consumerism both outside and inside the NHS was increasingly important over the whole period, and was discussed in detail in Chapter 5. Standing out against this trend, the 1999 *Guidelines* were more typical of NHS drug treatment policy-making that showed minimal consumer input. Like other expert committees in the drugs field, such as the Advisory Council on the Misuse of Drugs (ACMD), the working group's membership lacked any patients, although there were two ex-users on a subgroup.

The 1999 Guidelines

Origins of the Third Edition

It might be expected that any clinical guidelines would need updating every few years to reflect changing circumstances and knowledge, and the source of the particular impetus for the 1999 edition seems to have been Professor John Strang, Chairman of the 1991 and 1999 *Guidelines* working groups, with the support of Anthony Thorley, a Maudsley-trained psychiatrist and Senior Medical Officer at the Department of Health, and Alan Macfarlane, Chief Inspector of the Home Office Drugs Branch.

In 1996, the Department of Health had published the report of the Task Force to Review Services for Drug Misusers in England, known as the 'Effectiveness Review', which, as well as commissioning new research, attempted to review all the evidence on treatment and services for drug users in the largest such undertaking at that point.¹² In its introduction, it had made clear that the Department of Health was already intending to issue new guidelines on the clinical management of drug misuse to replace the 1991 edition. This may have been to reflect the newly reviewed literature, and perhaps also in response to the Review's own recommendation about the need to restrict prescribing of injectable drugs to particular doctors, which had originated with John Strang.¹³

In addition to producing the 1999 *Guidelines* document itself, the Working Group was asked to make a number of unpublished recommendations to ministers, covering four areas:

¹¹ UK Health Departments, *Drug Misuse and Dependence. Guidelines on Clinical Management*, (London: The Stationery Office, 1999) pp.9-15.

¹² The Task Force to Review Services for Drug Misusers, *Report of an Independent Review of Drug Treatment Services in England*, (London: The Stationery Office, Department of Health, 1996).

¹³ *Ibid.* p.67.

- a system for licensing doctors to prescribe controlled drugs for the treatment of drug misuse;
- training of clinicians;
- monitoring prescribing practice and
- improving the supervision of consumption of prescribed controlled drugs.¹⁴

Selection of the Working Party

A number of important differences strike the reader when comparing the membership of the 1999 Clinical Guidelines Working Group with its predecessors: the membership was not exclusively medical. The letter of invitation from Sir Kenneth Calman, Chief Medical Officer, said that there was a need to 'acknowledge the active role now played by other professionals'.¹⁵ Nurses, pharmacists, social workers, psychologists and the voluntary sector had been widely involved in drug treatment well before the first guidelines were written, so it is pertinent to ask why this had not been reflected until the late 1990s.

Among expert committees in drugs policy, the ACMD had become less medically dominated since its origins in 1971, and the Effectiveness Review's Task Force (1994-1996) had been overwhelmingly drawn from the non-medical world. With the wider rise in consumerism and the questioning of the bases of many kinds of authority and privilege since the 1960s, the areas in which doctors could claim 'medical autonomy', free from the influence of outsiders, were under constant pressure over this period, but they had successfully defended prescribing as their sole preserve. In drug treatment services, doctors remained the only professionals able to sign prescriptions for controlled drugs.

In 1982, the ACMD's *Treatment and Rehabilitation* working group had recommended that the first guidelines be produced by an all-medical group, feeling unable to comment on prescribing issues itself (see Chapter 3). However, despite medical attempts to hold off increased non-medical influence, sometimes successfully, prescribing eventually succumbed to at least a public acknowledgement of non-medical input in 1996. For the '99 *Guidelines* this took the form of Roger Howard, Chief Executive of the Standing Conference on Drug Abuse representing voluntary services, Professor Jean Faugier, a nursing specialist in drug treatment, and an academic at

¹⁴ Department of Health, 'Paper CGWG(97)42 Recommendations to accompany clinical guidelines', (October 1997) Private archive.

¹⁵ Sir Kenneth Calman, Letter to Working Group Members, (5th November 1996), Private archive.

Liverpool University, and Dr Janie Sheridan, a senior research pharmacist, and long time collaborator with psychiatrist John Strang at the National Addiction Centre, London. Roger Howard seems to have followed in the traditions of the voluntary sector in the drugs policy community, speaking on behalf of the absent users, among other issues.^{16,17}

The Working Group also included for the first time representation from Northern Ireland in consultant psychiatrist Dr Diana Patterson, a representative from the GMC, Professor Andrew Sims, and two public health doctors, Dr Laurence Gruer, from Greater Glasgow Health Board (also a member of the ACMD) and Dr Sally Hargreaves from Kensington and Chelsea and Westminster Health Authority. In continuity with the 1991 version, Professor John Strang, Britain's most senior drug dependence psychiatrist, Director of the National Addiction Centre at the Maudsley Hospital and Institute of Psychiatry, chaired the group for the second time.

Addiction psychiatrists had managed to maintain their position as the expert authorities in the drug treatment field, and this was reflected in the balance of the group, where they made up the largest specialism, numbering seven out of the eighteen members. In addition to those already mentioned were Eilish Gilvarry from Newcastle, Philip Fleming from Portsmouth, Mary Rowlands from HM Prison, Bristol and Duncan Raistrick from Leeds, who was also the Chief Medical Officer's Clinical Advisor on Alcohol Misuse, and chaired the '99 *Guidelines* subgroup on injectable prescribing.

The four general practitioners, Clare Gerada (London), Christine Ford (London), William Clee (Cardiff) and Judy Bury (Edinburgh) all had special experience in drug problems. Dr Gerada was to become a part-time senior policy advisor at the Department of Health, and with Michael Farrell took on the drafting of the Guidelines from 1998 after Anthony Thorley's departure.¹⁸ Professor John Henry, a clinical pharmacologist and authority on ecstasy was also a member.

Private medicine was represented by Dr David Curson, also a member from 1991. The Association of Independent Practitioners in the Treatment of Substance Misuse (AIP), representing private prescribers, had hoped that psychiatrist Colin Brewer could join the Working Group,¹⁹ but made the suggestion too late after the group had been set up as it was not until December that year that

¹⁶ L. Gruer, Interview by Sarah Mars, (2003).

¹⁷ S. Mars and V. Berridge, 'Social Science Small Grant End of Project Report Ref No: SGS/00742/G, The impact of drug user patient groups ('user groups') on UK drug treatment policy since the 1970s.' [unpublished] (2002).

¹⁸ Anonymous, 'Clinical Guidelines Working Group – Note of the meeting of 16th March 1998', File 16 DRU 323/12 Vol 1. DH Archive, Nelson, Lancashire.

¹⁹ AIP, 'Private prescribing and treatment for drug users', [Minutes of meeting] (13th March 1997), Private archive.

the AIP's first meeting took place.²⁰ Dr Brewer ran the Stapleford Clinic, a large private prescribing practice that also carried out rapid opiate detoxification under sedation/anaesthesia, the practice of which Professor Strang was publicly critical.²¹

The Association of Independent Prescribers (AIP) commented that 'if private prescribers were left out of the policy and decision making in respect of the Guidelines then it would not be viewed as a collaborative effort',²² and the private prescribers were minimally involved in the process. The chairman *had* in fact opted for representation of the private sector, but not of private prescribers: David Curson was employed by The Priory hospitals, whose practice lay outside the private prescribing controversy as it did not involve substitute prescribing on an outpatient fee-paying basis. In-patient treatment in private hospitals and residential facilities was associated with the abstinence based Minnesota Model, also known as '12-step' and familiar through Alcoholics Anonymous and Narcotics Anonymous.²³ A member of the secretariat described Dr Curson as 'the acceptable face of private practice' who was in favour of 'getting the rogues in Harley Street'.²⁴ The choice of David Curson therefore gave the Working Group representation from the private sector while avoiding internal opposition from private prescribers, against whom John Strang, like his predecessor Philip Connell, also a consultant psychiatrist at London's Maudsley Hospital, had long been active.^{25,26}

While Dr Brewer would have been an unlikely choice for the chairman to make, the likelihood of the chairman or Department of Health feeling compelled to invite a private prescriber onto the committee suggested a certain naïveté about the selection process, and perhaps an over-estimation of their own importance in the 1990s. Added to this, in contrast with 1984, when the Association for Independent Doctors in Addiction (AIDA) was a prominent organisation, the position of private prescribers in November 1996, when the letters of invitation were sent out, was further weakened by their lack of a representative body.

²⁰ AIP, 'Private prescribing and treatment for drug users', [Minutes of meeting] (10th December 1996), Private archive.

²¹ J. Strang, J. Beam, M. Gossop, 'Opiate detoxification under anaesthesia', *British Medical Journal*, 315 (1997), 1249-1250.

²² AIP, (13th March 1997) *op. cit.*

²³ D. Curson, (1991) *op. cit.*, pp.9-10.

²⁴ A. Thorley, Interview by Sarah Mars (2002).

²⁵ eg J. Strang, J. Sheridan and N. Barber, 'Prescribing injectable and oral methadone to opiate addicts: results from the 1995 national postal survey of community pharmacies in England and Wales', *British Medical Journal* 313 (1996), 270-272.

²⁶ In addition to Professor Strang's published criticisms of private prescribing, he has also appeared as an expert witness to give evidence against private practitioners in a number of disciplinary hearings by the GMC and Home Office Drug Tribunals.

The membership of the 1984 Guidelines working group, formed under Philip Connell's chairmanship, had aimed to incorporate within it the 'opposition', in the form of two private prescribers and representatives of AIDA, Drs Ann Dally and Dale Beckett, although this did not mean that their views were represented in the final publication. By 1996, when the '99 Guidelines Working Group was being formed, the divisions within the drug treatment field had changed.

In the early 1980s, allowing for a little simplification, the field was divided between those who only supported prescribing regimes aimed at achieving abstinence from opiates within a relatively short time, using oral formulations, and those who saw some place for longer term prescribing or maintenance and favoured a choice between oral and injectable drugs, whether heroin or methadone. These issues had been played out in the first guidelines working group, resulting in strict advice against long term prescribing, and presenting oral methadone detoxification as the only option for opiate dependence.

By the late 1990s, the influence of 'harm reduction', a pragmatic response intended to reduce HIV transmission from injecting drug use, and seen by some as a lever to liberalise the drug laws, had made methadone maintenance much more widely accepted in the treatment policy community in Britain and many other countries. Although methadone maintenance still provided controversy on the '99 Guidelines working group,²⁷ with the accumulation of strong research evidence and the support of those in influential positions, including the chairman, opposition proved ineffective. Furthermore, some of the Clinic system's most vocal critics, including Dr Ann Dally and Dr John Marks, the outspoken Liverpool Clinic psychiatrist who practiced publicly and advocated heroin prescribing for opiate addicts, had lost their platforms. Ann Dally had ceased treating drug users after the GMC's second ruling against her and had stopped participating in the debate in the late 1980s, while John Marks had moved to New Zealand after health authority funding was withdrawn from his Clinic.

The issue of private prescribing had also become relatively less significant, remaining concentrated in the South East while NHS drug services had spread in density across the country, involving increasing numbers of the medical profession. No longer was the cause of 'harm reduction' heard mainly from private doctors and a small number of GPs working outside the hospital-based Clinics. A greater consensus had emerged following the policy response to HIV/AIDS between doctors inside and outside the Clinics, and although divisions remained, strong differences of view

²⁷ C. Ford, Interview by Sarah Mars (2002).

to those dominant in the policy community, such as those held by many doctors practising privately, had become more marginal and a smaller minority of those providing treatment.

The importance of patients achieving abstinence from all illicit and substitute drug use had been a central principle among those dominant in the treatment policy community of the 1980s, and was expressed through the '84 Guidelines. Small steps towards the more pragmatic approach of harm reduction were evident in the '91 Guidelines, with apparent consensus regarding these goals on the '99 Working Group, whose second meeting was minuted as follows: 'There was general agreement that the primary role of the doctor is not to ensure that individuals become drug-free – that is a moral issue – but to reduce the harm to individuals. However, where abstinence is essential to, or an efficient means of, reducing harm, that will be one of the goals of treatment. This message will inform the drafting of the Guidelines.'²⁸

'General agreement' may still have allowed some room for dissent. Some disagreement on these principles, and in particular methadone maintenance prescribing, came from Dr Diane Patterson, Chair of the Northern Ireland Committee on Drug Misuse.²⁹ In spite of the greater consensus on the content of treatment that had followed policies around HIV, areas of disagreement still existed within the Working Group. One dimension along which there was a range of views could be described as the extent to which the demands of public health or the individual patient were seen as paramount in prescribing decisions, a familiar theme in drugs policy across the UK. For instance, Dr Laurence Gruer, a consultant in public health medicine with Greater Glasgow Health Board, favoured indefinite supervised consumption of methadone by patients to protect others from the risks from diverted supplies.³⁰ Chris(tine) Ford, a west London NHS GP and passionate advocate for the rights of drug users, who had been described as an 'NHS private prescriber', thought there should be no such stipulations, commenting, 'If you keep people on supervised consumption forever then they aren't allowed to move on or grow in any way. If you treat them like a child they behave like a child.'³¹ Gruer himself agreed that the primary care side showed more of a sense of direct engagement with individuals, whereas the psychiatrically oriented members took a more intellectual approach.³²

²⁸ Department of Health, 'Clinical Guidelines Working Group Note of meeting held on Friday 7th November 1997 at Waterbridge House' (Undated). Private Archive.

²⁹ C. Ford, (2002) *op. cit.*

³⁰ *Ibid.*

³¹ *Ibid.*

³² L. Gruer, (2003) *op. cit.*

It could be argued that the greatest disagreement existed between doctors on the Working Group and those GPs outside who refused to prescribe substitute drugs to drug users unless they received additional payment, which with the exception of a few local arrangements, was not forthcoming. The split this caused between 'experts' and 'ordinary' GPs (or their GMS representative) had erupted on the British Medical Association's Working Party on Drug Misuse between 1995 and 1997 and produced almost complete paralysis for a portion of its fraught existence.³³ John Strang, an approachable man with an un confrontational approach to committee discourse, had found the BMA Working Party a jarring experience which may have determined him to choose GPs for his own working group not for their representativeness, but for their expertise and enthusiasm.^{34,35} While the first guidelines working group had brought inside the opposition, in the form of Ann Dally and Dale Beckett, but then ignored its views,³⁶ membership of the third working group not only represented the greater degree of consensus of its time, but was also chosen for their ability to work together productively.³⁷

As well as the Working Group itself, there were a number of sub-groups brought together to examine particular issues and report back. Some of these, such as the private prescribing sub-group, were made up of existing members and secretariat or observers.³⁸ Others, like the injectable prescribing sub-group brought in outsiders including, for the first time, some patient representatives. These were two ex-users who were 'adamant against injectables' after experience of such prescribing, according to one member. They had been chosen by Duncan Raistrick, the subgroup's chairman, described as 'not a keen lover of injectables' himself.³⁹

In addition to the members were a number of medical observers representing the Welsh Office, the Department of Health and Social Services, Northern Ireland, the Scottish Home and Health Department and the Prison Service Health Care Directorate. Particularly important to the licensing issue was Alan Macfarlane, the non-medical Chief Inspector at the Home Office Drugs Branch. Reflecting the proliferation of drugs agencies within central government, there were also observers

³³ The author was researcher to the British Medical Association's Working Party on Drug Misuse (1995-97).

³⁴ J. Strang, Interview by Sarah Mars, (2002).

³⁵ L. Gruer, (2003) *op. cit.*

³⁶ S. Mars, 'Peer Pressure and Imposed Consensus: The Making of the 1984 "Guidelines of Good Clinical Practice in the Treatment of Drug Misuse"' in V. Berridge (ed.), *Making Health Policy: Networks in Research and Policy After 1945* (Amsterdam: Rodopi, 2005) pp.149-182.

³⁷ J. Strang, (2002) *op. cit.*

³⁸ Department of Health. CGWG (97) 26, 'Private practice and the prescribing of controlled drugs', (June 1997), Private archive.

³⁹ C. Ford, (2002) *op. cit.*

from the Central Drugs Coordination Unit or UK Anti-Drugs Coordination Unit. The secretariat also included non-medical civil servants, Rosemary Jenkins and Fred Pink.

What the '99 Guidelines said

Unlike the first *Guidelines*, these opened by providing some context about prevalence and trends in drug use in society and contemporary government strategies. All three editions prominently made the point that every doctor should treat drug users for both general medical and drug related problems. In the years before the '99 version, this had become a topic of disagreement between the Department of Health and the British Medical Association's General Medical Services Committee (GMSC), the GPs' main trade union. From 1996 the GMSC had argued that treating drug problems lay outside their obligatory workload (core general medical services) and should be separately remunerated as a specialist activity,⁴⁰ but had failed to persuade central government of its case.

Like the 1984 document, a key aim of the '99 *Guidelines* was to allocate appropriate activities to different doctors as a basis for extending licensing and for disciplinary action. To do this it introduced a new category, the 'specialised generalist' in between the 'generalist' and the 'specialist'. This super-GP was not restricted to the drugs field but reflected the increased power, status and domain of general practice that had accompanied the flow of resources into primary care in the 1990s. The three categories were differentiated by experience, the proportion of their patients who needed treatment for drug problems, levels of training that they should receive (including qualifications for the specialists) and give to others, and the requisite degree of autonomy or collaboration with others. The kind of prescribing to be undertaken was also specified, with specialists the only group to prescribe injectables, for which they would require a new Home Office licence.

The aims of treatment showed a balance between harm reduction and abstinence oriented approaches, by stating that the ultimate aim was a drug-free patient, but intermediate goals should be pursued until this was possible. Criminal justice or public health concerns such as preventing diversion of drugs onto the illegal market were also included as a treatment goal, as well as reducing 'the need for criminal activity to finance drug misuse'.⁴¹ The absence of patient representation and influence on the Working Group was reflected in some statements such as, 'Due notice should be

⁴⁰ British Medical Association. General Medical Services Committee, *Core Services: Taking The Initiative* (London: British Medical Association, 1996).

⁴¹ UK Health Departments, (1999) *op. cit.*, p.7.

given of a reduction regime', suggesting that change should not be imposed suddenly and without warning on patients, but neither was the patient's agreement necessary.⁴²

Considerable space was given to describing 'shared care' arrangements, an approach favoured by the Department of Health. Voluntary drug services were included in the overall picture of available services. The chapter on assessing patients' needs and situations repeated the '91 *Guidelines*' warning that in private practice the doctor should 'establish that the patient is able to pay for treatment through legitimate means'. Despite the mantra repeated in the '99 *Guidelines* and in official documents since the second Brain Report,⁴³ that prescribing was only part of an overall approach to treatment and rehabilitation requiring psychological and other input, prescribing remained the focus here, taking up four of the seven chapters. Prescribing remained the most controversial area, and perhaps the one seen by addiction psychiatrists and policy makers as having the potential to cause the greatest harm. Only one page was devoted to 'broader approaches to psychosocial support and treatment'.⁴⁴

Opiate prescribing had long been the mainstay of prescribing debates, and it occupied the most space here. Possibly the most significant prescribing changes from previous editions of the *Guidelines* were the endorsement of methadone maintenance as an activity suitable for primary care and the much strengthened and more specific recommendations for daily 'supervised consumption', where patients' prescribed drugs would be taken under the observation of a pharmacist or doctor. Although containing many caveats, the advice on amphetamine substitution was also a new departure, for the first time conceding, 'There may be a limited place for the prescription of dexamphetamine sulphate 5 mg (five) in the treatment of amphetamine misuse.'⁴⁵ Less new was the proposed licensing system for prescribing doctors that sought to restrict injectable prescription to specialists. Although not publicised in 1984, this had also been advocated by that guidelines working group (see Chapter 4).

The revival of international interest in heroin prescription, partly influenced by the positive results from a rigorous clinical trial in Switzerland,⁴⁶ may have prompted the first ever appearance of a section on this topic in the '99 *Guidelines*. Strangely no evidence was cited in the single paragraph

⁴² *Ibid.* p.31.

⁴³ Interdepartmental Committee on Drug Addiction, *Drug Addiction. The Second Report of the Interdepartmental Committee* [second Brain Report], Ministry of Health, Scottish Home and Health Department, (London: HMSO, 1965) p.9.

⁴⁴ UK Health Departments, (1999) *op. cit.*, p.63.

⁴⁵ *Ibid.* pp.42-43.

⁴⁶ A. Uchtenhagen, F. Gutzwiller and A. Dobler-Mikola, *Programme for a Medical Prescription of Narcotics: Final Report of the Research Representatives. Summary of the Synthesis Report* (Zurich: University of Zurich, 1997).

which concluded, 'With the availability of injectable methadone, there is very little clinical indication for prescribed diamorphine.'⁴⁷ A similar section appeared on injectable prescribing, describing it as a specialist only activity.⁴⁸

The extensive annexes covered a range of technical, legal, procedural and practical issues such as drug interactions, prescribing to minors, special prescription requirements for controlled drugs, dealing with potentially violent patients, and special considerations such as pregnant patients. They also included 'harm minimisation' advice for patients, such as how to clean a syringe with household bleach, an updated and extended version of the 1991 guidance. The tone of these *Guidelines* did not seem designed to make the tasks described appear easy or straightforward as the first edition had and were scattered with numerous cautions on risks, pitfalls and safety precautions.

Evidence-based Medicine

Although the 1999 edition of the *Guidelines* was the most densely referenced of the series, and 'relied substantially on the major undertaking of the Task Force to review the evidence base for services for drug misusers', they were not the dramatic departure from the past that might have been expected in an age of 'evidence-based medicine'.⁴⁹ Many previous reports published in the 1980s and 1990s from expert committees in the drugs field had relied heavily upon the authority of their contributors' body, such as the ACMD's *Treatment and Rehabilitation*, or the first two editions of the *Guidelines*, and contained very few references to published research evidence. In 1999, despite a considerable increase in publication on clinical drug research in the UK and across the world, the *Guidelines*' introduction, under the heading, 'Evidence-based Guidelines', stated that they were 'primarily based on evidence obtained from expert committee reports and the clinical experience of respected authorities'.⁵⁰ Indeed, the section on maintenance prescribing, although referencing research reviews, looked to a quotation from an ACMD report for support, a document which contained only 36 references, several of which were policy documents and other ACMD publications.⁵¹ Once again, it seemed, treatment policy was to be determined by 'respected authorities' albeit with some extra research backing.

⁴⁷ UK Health Departments, (1999) *op. cit.*, p.57.

⁴⁸ *Ibid.* p.55.

⁴⁹ *Ibid.* p.xiv.

⁵⁰ *Ibid.* p.xiv.

⁵¹ ACMD, *AIDS and Drug Misuse Update*, Department of Health (London: HMSO, 1993) p.53.

Purpose of the 1999 Guidelines

The '84 *Guidelines* had a number of clear-cut aims in the minds of the key movers behind them, from the original recommendation in the ACMD's *Treatment and Rehabilitation*, to the final document. These were the strengthening of the position of the Clinic psychiatrists and the authority of their model of treatment and the control of prescribing by doctors working outside the Clinics, most specifically private practitioners, through greater regulation (see Chapters 3 and 4).

At the '99 *Guidelines* working group, prescribing outside the Clinics remained a concern, and was addressed through the group's recommendations on licensing.⁵² The emphasis here was slightly different to that of the post-1968 heroin and cocaine licensing. Instead of doctors' suitability for licensed prescribing being based upon their specialty and location of work, something it was hard for GPs, for instance, to change, under the new system's design a doctor who was able to gain sufficient extra training and experience should have been able to qualify for a specialist licence.

One important theme of the '99 *Guidelines* themselves, and the meetings of the working group, was defining primary and specialist treatment more clearly. This seems to have served a number of functions. The Department of Health's favoured approach for encouraging greater GP participation in drug treatment was the promotion of 'shared care' where GPs and specialists collaborated over a patient's care (see footnote 84). Such definitions could remove ambiguities and help show GPs what was involved in this work. Also, in his evidence against Adrian Garfoot at that doctor's Home Office Misuse of Drugs Tribunal in 1994, John Strang spent some time wrestling with the appropriate distinctions between specialist and generalist addiction services, and this may have inspired him to seek firmer, formal definitions.⁵³ Marking clearly what was suitable prescribing for primary care would also prevent what was perceived as undesirable prescribing in the first place and make disciplining those who stepped outside the definition easier, either through GMC hearings or through the withdrawal of any licence.

It might have been expected that the changed view towards maintenance prescribing as suitable for primary care, which came about with the '99 *Guidelines*, would bring with it greater autonomy for GPs, but the reverse seemed to have been the case. The move toward methadone maintenance as

⁵² Macfarlane, A. 'Changes to the misuse of drugs legislation of controlled drugs prescribe in the treatment of addiction', [Consultation document] (London: Action Against Drugs Unit, Home Office, 17th March 2000).

⁵³ *In the Matter of the Misuse of Drugs Act 1971 and In the Matter of Dr John Adrian Garfoot. Minutes of Proceedings at a Misuse of Drugs Tribunal* (England and Wales), (22nd June 1994), W. B. Gurney and Sons [transcript], GMC Archive, London. pp.42-58.

a widely accepted treatment approach could be traced from the '84 *Guidelines* to the '99 edition. The first *Guidelines* ruled out maintenance entirely from primary care,³⁴ and the '91 post-HIV edition refused to describe it, considering it 'a specialised form of treatment best provided by, or in consultation with, a specialist service,'³⁵ going on, 'A doctor who feels that a patient is likely to require prescription of an opioid drug for more than a few months should seek advice and support from the local specialist in drug misuse.' The '99 *Guidelines* put great emphasis on the proven efficacy of methadone maintenance, but still expressed caution about the ability of ordinary GPs to prescribe any substitute drug unsupervised: 'Only in exceptional circumstances should the decision to offer substitute medication without specialised generalist or specialist advice be made.'

In spite of the more consensual nature of the '99 Working Group, a last disagreement seems to have almost upset the whole process. After the final meeting, three of the four GPs, Chris Ford, Judy Bury and William Clee, wrote to the secretariat, threatening to remove their names from the final document. They protested that the draft produced by the secretariat after the final meeting of the group on 16th March 1998, from which Drs Ford and Clee had been absent, was radically different to previous versions.

An examination of the drafts prior to and following the final Working Group meeting did reveal substantial changes both in structure and content.^{36,37} Methadone maintenance was newly given much greater emphasis than any other intervention, many of the chapters, such as 'Young People and Drugs', 'Pregnancy and Neonatal Care' and 'Managing Drug Misuse Emergencies' were reduced in size and turned into annexes. Other controversial topics, such as stimulant and injectable prescribing, were altered to sound less positive. But minutes of the final meeting recorded that these changes had in fact been suggested by the Working Group,³⁸ rather than effected through the secretariat conspiracy suggested by the GPs' letters.^{39,40} One might speculate that in the absence of some of the group's more liberal individuals who opposed greater regulation and controls, the other members took advantage to press through their own preferences. Supporting this view was the fact that the secretariat took on board some of the complaints made

³⁴ Medical Working Group on Drug Dependence, (1984) *op. cit.*, p.1.

³⁵ Department of Health, Scottish Office Home and Health Department and Welsh Office, (1991) *op. cit.*, p.22.

³⁶ Department of Health, Draft sent to Clinical Guidelines Working Group on 5th March 1998, (undated) Private archive.

³⁷ Department of Health, Draft sent to Clinical Guidelines Working Group on 3rd July 1998, (undated) Private archive.

³⁸ Anonymous, 'Clinical Guidelines Working Group – Note of the meeting of 16th March 1998', File 16 DRU 323/12 Vol 1. DH Archive, Nelson, Lancashire.

³⁹ W. Clee, Letter to M. Davies, (30th July 1998), Private archive.

⁴⁰ C. Ford, Letter to M. Davies, (18th July 1998), Private archive.

about these changes to the satisfaction of the GPs,⁶¹ and they decided to endorse the document. Consensus was therefore achieved more democratically inside the group than at the 1984 guidelines working group: Ann Dally and other 'dissidents' had intended to produce a minority report in 1984, but the opportunity was circumvented by the chairman and secretariat through a sudden behind-the-scenes change in committee procedure so the final document gave a false appearance of accord (see Chapter 4).

One member leaked the '99 *Guidelines* before they were finalised, along with quotes from the minutes of a Working Group meeting to *Druglink*, the bulletin of the Institute for the Study of Drug Dependence, in what seems to have been an attempt to whip up opposition to the licensing recommendations and get them modified. The response to this leak from the chairman was reportedly quite tolerant.⁶² The Department of Health was aware that 'the culprit was a member of the independent working group...on the grounds that the article quotes directly from the minutes of the last meeting of the group which were sent only to members.'⁶³ It is not clear whether the civil servant knew or suspected which member was responsible, but if he did, no action was taken.⁶⁴

The main opposition to methadone maintenance arose from Belfast psychiatrist Diane Patterson. This was the first time that the guidelines had included Northern Ireland, where there was neither methadone prescription nor official needle exchanges.⁶⁵ While Northern Ireland had been happy to copy the first guidelines almost to the letter, bringing out their own edition, the developments of the intervening years in the direction of harm reduction had been resisted in Northern Ireland. Dr Patterson claimed that the emphasis on substitute prescribing for opiate addiction 'would place Doctors in Northern Ireland in an impossible position', and consequently she would be advising the Chief Medical Officer of Northern Ireland not to adopt the guidelines pending the final publication.⁶⁶ This disagreement pointed up geographical differences in prescribing traditions, which Laurence Gruer considered one of the main sources of divergence across the working group.⁶⁷

⁶¹ eg J. Bury, Letter to F. Pink, (12th October 1998), Private archive.

⁶² Working Group member, Interview by Sarah Mars, (2002).

⁶³ M. Davies, Memo to K. Jarvie, 'Drug Misuse Clinical Guidelines – Leak of Working Papers' (1st July 1998), File 16/DRU 323/22 Vol 1, DH Archive, Nelson, Lancashire.

⁶⁴ Working Group member, Interview by Sarah Mars, (2002).

⁶⁵ K. McElrath 'Heroin Use in Northern Ireland: A Qualitative Study Into Heroin Users' Lifestyles, Experiences And Risk Behaviours (1997-1999)', (Belfast: Department of Health, Social Services and Public Safety, 2001).

⁶⁶ D. Patterson, Letter to M. Davies, (8th July 1998) File 16 DRU 323/12 Vol 1, DH Archive, Nelson, Lancashire.

⁶⁷ L. Gruer, (2003) *op. cit.*

Dr Patterson's stand over the document seemed to have been prompted by the peculiar placing of a section entitled 'Methadone maintenance – the evidence' in the introduction to the document circulated after the last meeting. The text appeared before the discussion of any other aspect of treatment, as if transplanted, giving it an unnatural prominence.⁶⁸ The medical secretariat, Claire Gerada and Michael Farrell, tried to respond to these issues by arranging a meeting with the chief critics, Diana Patterson, Chris Ford, William Clee and possibly Judy Bury the following month.⁶⁹

Although placated with regard to the *Guidelines*, Ford and Clee remained unhappy about the licensing proposals and both signed a letter to *Druglink* opposing them. They saw these as specifically aimed at curbing 'the prescribing habits of a few private doctors in London' and being harmful to all drug users trying to access treatment.⁷⁰ Although suspicious of private health care in general, Chris Ford echoed many of Ann Dally's arguments in the 1980s. Both expressed concerns about treatment for patients suffering withdrawal symptoms during assessment – the period when a patient had presented for treatment and the appropriate course of action was being decided.^{71,72} Both were critical of the NHS Clinics and saw private treatment not as an ideal but as legitimately revealing shortcomings in existing NHS provision.^{73,74,75} After the final meeting of the Working Group which had endorsed an extension of licensing, Chris Ford wrote to the chairman and secretariat in words that could have been written by Dally herself asking, 'What is going to happen to many drug users being provided services by the private sector, and perhaps many GPs who do not prescribe like the local specialist services? Many users are managed in general practice and the private sector because the NHS can't or won't provide the care they want or require.'⁷⁶ They also shared concerns about the dignity of patients in drug misuse treatment, expressing greater trust in them than many of their colleagues.^{77,78} Ford commented of her patients, 'If you believe people, they tend to tell you the truth.'⁷⁹

⁶⁸ Clinical Guidelines Working Group, Draft guidelines, (3rd July 1998) [draft B].

⁶⁹ Anonymous, 'Clinical Guidelines – Action Points 22nd July '98', File 16, DRU 323/12 Vol 1, DH Archive, Nelson, Lancashire.

⁷⁰ B. Beaumont, T. Carnworth, W. Clee, *et al.* (2001), *op. cit.*, p.25.

⁷¹ AIDA, *AIDA Comments on "Guidelines of Good Clinical Practice in the Treatment of Drug Misuse" DHSS 1984* (July 1985), File PP/DAL/B/4/1/1/8, Wellcome Library, London.

⁷² C. Ford, (2002) *op. cit.*

⁷³ A. Dally, Letter to J. Munro, (22nd January 1982), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

⁷⁴ C. Ford, Facsimile to D. Raistrick Re DoH Injecting Subgroup, (1st June 1997). Private archive.

⁷⁵ C. Ford, (2002) *op. cit.*

⁷⁶ C. Ford, Letter to J. Strang, C. Gerada, M. Farrell and M. Davies 'Re: Clinical Guidelines Working Group – Notes of the meeting of 16th March', (24th May 1998), Private archive.

⁷⁷ C. Ford, (2002) *op. cit.*

⁷⁸ see A. Dally, *A Doctor's Story*, (London: Macmillan, 1990).

⁷⁹ C. Ford, (2002) *op. cit.*

Hovering around the issue of these *Guidelines* was the question of whether they were, in fact, intended to be 'guidelines', to suggest a path to doctors or rather tools for disciplining them. In both 1984 and 1999 there were attempts to introduce statutory regulations to make the *Guidelines* compulsory, but both failed. The ACMD had expressed the intention, in *Treatment and Rehabilitation*, for the prospective '84 Guidelines to be used as conditions in licensing once it had been extended to cover all opioid drugs.⁸⁰ Similarly, the first proposals from the Home Office and Department of Health to the 1999 Working Group for an extension of licensing was presented as a system of statutory control to enforce the *Guidelines*.⁸¹

Regulatory control seems to have been a strong impulse in both 1984 and 1999 but perhaps less so in 1991 when the second edition was published. The '84 edition hoped that 'these guidelines would help to identify those cases where prescribing practices might be regarded as irresponsible.'⁸² The '91 edition made no mention of any regulatory role, but the '99 Guidelines gave a stern warning that although they had 'no defined legal position...any doctor not fulfilling the standards and quality of care in the appropriate treatment of drug misusers that are set out in these Clinical Guidelines, will have this taken into account if, for any reason, consideration of their performance in this clinical area is undertaken.'⁸³

Like the '84 *Guidelines*, the '99 document was intended to control private prescribing (see Chapter 4) but this was a much smaller part of its wider concern to define and regulate the appropriate practices of primary and secondary services with a view to both encouraging and controlling treatment outside the psychiatrist led Clinics. While the issue of private prescribing played a part in the 1999 group's considerations, particularly in the questions of licensing and the prescribing of injectable opiates, the prominence of this almost exclusively south eastern phenomenon in the wider drug treatment scene had diminished with the expansion of NHS services across the country and the participation of many more general practitioners treating drug misuse.

The '99 *Guidelines* were in fact intended not just for the guidance or discipline of doctors, but also to reshape services they provided. While the '84 *Guidelines* were primarily aimed at doctors working outside the Clinics, the Inspectorate and the GMC, the '99 *Guidelines* were additionally targeted at the bodies responsible for medical training and resourcing, including the Department of Health.

⁸⁰ ACMD. *Treatment and Rehabilitation*. DHSS, (London: HMSO, 1982) pp.57-60.

⁸¹ A. D. Macfarlane, CGWG (97) 17, 'Clinical Guidelines Working Group. Note by the Home Office on Licensing', Home Office, (8th May 1997), Private archive.

⁸² Medical Working Group on Drug Dependence, (1984) *op. cit.*, p.3.

⁸³ UK Health Departments, (1999) *op. cit.*, p.xv.

They made recommendations, such as those around supervised consumption of methadone, that had spending implications, and expected government to respond accordingly. In this respect the '99 Working Group was given a wider remit than its forebears.

Extending Licensing

Before the 1990s

The three categories of doctor laid out by the '99 *Guidelines* represented 'a continuum by which the development of shared care arrangements,⁸⁴ training, provision of resources and Home Office licensing arrangements can be targeted.⁸⁵ While the licensing implications were touched on only lightly in the *Guidelines*, more details were sent in the Working Group's confidential recommendations to ministers.⁸⁶ But although this triadic division was new in regulatory terms, the concept of extending the licensing system introduced in 1968 had been around as long as the Clinics themselves. A Department of Health meeting of the London Clinic psychiatrists had proposed that *all* dependency producing drugs to known addicts, not just heroin and cocaine, should be removed from GPs and limited to the Clinics, but the proposal had been rejected by the Department as too expensive.⁸⁷

As discussed in Chapters 3 and 4, the idea was revived in 1980, and pushed forward in the ACMD's *Treatment and Rehabilitation* report, this time aimed more at controlling private doctors than general practitioners. In 1984 a vote on the issue by the first clinical guidelines working group found a majority in favour, but the government delayed taking action. A year later, in 1985, the Social Services Committee (SSC), whose remit of scrutiny included the expenditure, administration and policy of the DHSS, looked into drug misuse, treatment and rehabilitation, and made similar recommendations. 'These were to extend licensing to cover all injectable opiates and restrict licences to 'doctors working in, or under the direct supervision of, a consultant or equivalent in a clinic'.⁸⁸

⁸⁴ 'Shared care' is described by the '99 *Guidelines* as 'a model that can be applied to any close cooperative work between agencies or services, which directly improves the treatment of the individual drug misuser. It most often involves arrangements between specialist and general practitioner services'. p.10.

⁸⁵ UK Health Departments, (1999) *op. cit.*, p.4.

⁸⁶ Clinical Guidelines Working Group, 'Prescribing and Licensing Regulations' [attached to minutes of 16th March 1998], Department of Health, (1998) File 16/DRU 323/12 Vol 1, DH Archive, Nelson, Lancashire.

⁸⁷ J. L. Reed, "Meeting of Doctors Working in London Drug Dependency Treatment Centres, November 25th, 1969 at St Bartholomew's Hospital" [Minutes], Private archive.

⁸⁸ House of Commons Social Services Committee, *Misuse of Drugs with Special Reference to the Treatment and Rehabilitation of Misusers of Hard Drugs. Fourth Report of the Social Services Committee, Session 1984-85*, (London: HMSO, 1985) p.xxv.

The SSC had been advised by Dr Martin Mitcheson, Consultant at University College Hospital Drug Dependency Unit, a strong advocate of oral methadone prescription, member of the London Consultants Group, and opponent of private prescribing where the doctor was directly paid by patient fees.⁸⁹ The committee itself expressed great respect for the reports of the Advisory Council on the Misuse of Drugs,^{90,91} and seemed to have taken its line on prescribing regulation from these. At this stage, the government was yet to come to a decision about extending licensing and the Social Services Committee urged it to do so. It did, resolving that it was unnecessary and possibly likely to deter GPs from treating drug users.^{92,93}

The licensing recommendations of 1969, 1980, 1982, 1984 and probably 1985 came from senior psychiatrists seeking to contain and control prescribing, particularly of injectable or maintenance opiates, within the centralised state-funded Clinics, where the addiction psychiatrists developed and tried to maintain their monopoly of expertise. A similar pattern emerged in the late 1990s, but this time boosted by strong civil service support.

The 1990s

In the 1990s a new generation of politically active doctors had taken the reins, but shared many of the same concerns and had passed through the same training institution. The psychiatrists who pushed for greater regulation of doctors working outside the Clinics had been trained in the Maudsley Hospital under Philip Connell. John Strang, chairman of the '99 Guidelines working group was one of these doctors, following Connell into a number of his policy and clinical posts. Whereas in the 1980s these medical men lacked the support of key civil servants at the Department of Health and Home Office, in 1999 the psychiatrists and administration were united.

Alan Macfarlane, was frustrated by the Home Office's existing mechanisms for controlling prescribing and the lack of enforceable standards. Referring to 'a current tribunal case where the doctor's position was that the needs of his particularly difficult patient group justified an approach which involved enormous quantities of drug cocktails', he complained of the inadequacy of the '91 Guidelines for use in regulation: 'it is significant that the existing guidelines did not provide the Tribunal with a cut and dried benchmark.'^{94,95} Macfarlane saw the new Guidelines, reinforced by

⁸⁹ M. Mitcheson, Interview by Sarah Mars, (2003).

⁹⁰ ACMD, (1982) *op.cit.*

⁹¹ ACMD, *Prevention*, (London: HMSO, 1984).

⁹² D. Mellor, Letter to R. Whitney, (10th December 1985), File 16/DAC 28/2, DH Archive, Nelson, Lancashire.

⁹³ J. Patten, Letter to D. Mellor, (15th May 1985), File 16/DAC 28/2, DH Archive, Nelson, Lancashire.

⁹⁴ A. D. Macfarlane, CGWG (97) 3, 'Pharmaceutical Diversion and the Prescribing Dimension. Note by the Home Office Drugs Inspectorate', (3rd March 1997), Private archive.

extended licensing, as the solution to these problems. Anthony Thorley was in accord with Alan Macfarlane on this issue,^{96,97} but his departure may have altered the balance once again, weakening Macfarlane's position.

The idea of restricting injectable methadone prescription to particular doctors, however, had been in the mind of the chairman, Professor Strang, at least as far back as 1996 when attending the meetings of the Effectiveness Review in his capacity as Consultant Adviser to the Department of Health's Chief Medical Officer.⁹⁸ He had written to its chairman, Reverend John Polkinghorne, about the possibility of extending the licensing system to cover injectable drugs. In his attached draft, which was included largely unchanged in the Task Force's report, written after discussion with the Reverend Polkinghorne,⁹⁹ he discussed concerns about the prescription of injectable methadone, especially in private practice, and concluded:

We recommend that specialist drug misuse services (with doctors with appropriate training and expertise in this area) should direct more of their energies/activities to the patients who require this more specialist treatment. We then recommend that such prescribing of injectable drugs to drug addicts should be restricted to doctors with this appropriate training and expertise, working in services with adequate multidisciplinary input, and with systems in place to safeguard against abuse of this service and to prevent diversion of the prescribed injectable drugs into the black market.¹⁰⁰

Finally, the draft recommended, 'that the Department of Health should arrange for the development of guidelines on how these specialist clinicians should apply the necessary triage as to identify the more complicated cases for whom they will then have a particular responsibility to provide this specialist care.' This letter and draft were copied to Anthony Thorley at the Department of Health and the Effectiveness Review published a recommendation that 'The Department of Health should explore ways to ensure that injectable addictive drugs are only

⁹⁶ *Ibid.*

⁹⁶ A. Thorley, (2002) *op. cit.*

⁹⁷ A. Thorley, CGWG (97) 17, 'Clinical Guidelines Working Group (attached to CGWG(97)17 'Note by the Home Office on Licensing'), Home Office Licensing: The Options for Encouraging Good Clinical Practice', (May 1997), File 16 TFD-46 Vol. 5, DH Archive, Nelson, Lancashire.

⁹⁸ T. Waller, Interview by Sarah Mars, (2001).

⁹⁹ J. Strang, Letter to J. Polkinghorne, (29th November 1995), File 16/TFD-45 Vol 1, DH Archive, Nelson, Lancashire.

¹⁰⁰ J. Strang, 'Draft outline for conclusions and recommendations about the prescribing of tablets and ampoules of methadone', (undated; attached to J. Strang, Letter to J. Polkinghorne, 29th November 1995), File 16/TFD-45 Vol 1, DH Archive, Nelson, Lancashire.

prescribed for drug addicts by doctors (including GPs) with appropriate training and expertise working with adequate multidisciplinary input and by specialist drug misuse services.¹⁰¹

The addition of the bracketed inclusion of GPs hinted at a significant area of debate on the '99 *Guidelines* working group: what prescribing should be carried out by GPs, particularly those with additional training and experience (several of whom were members of the Working Group)? And should such GPs be able to prescribe in the same way as specialist psychiatrists in hospital-based settings? Right up to the final two drafts of the '99 *Guidelines*, there were changes between including only consultant psychiatrists as 'specialists' and allowing other doctors into this definition.

The significance of describing injectable prescribing as a specialist activity, and subject to a new type of Home Office licence, should not be missed. The appropriateness of injectable prescribing in private practice was an important part of the public-private debate and one that aroused John Strang's disapproval. His surveys of pharmacies were critical of doctors who prescribed injectable drugs in non-specialist settings.¹⁰² Data from a draft paper by Strang and Sheridan, comparing methadone prescribing in private and NHS practice, was also used in 1999 as evidence in the Royal College of Psychiatrists and Royal College of Physicians' criticisms of private doctors.^{103,104}

The '99 *Guidelines* group was asked to make recommendations but not to consider details of implementation, which was the realm of the Drugs Inspectorate. Although the Working Group specified that the Director of Public Health should be the countersigning officer for any licence application, it did not decide who should make the actual decision about the award of a licence. Here lay a large area of potential ambiguity that caused disquiet among doctors in the field.¹⁰⁵

The proposed extension of licensing in 1999 was intended by the Home Office and Department of Health to reduce diversion of pharmaceuticals and 'monitor good practice'.^{106,107} John Strang's aim seems to have been similar, with particular interests in restricting injectable prescribing and enforcing the supervised consumption and daily dispensing of methadone. He had already

¹⁰¹ Task Force to Review Services for Drug Misusers, (1996) *op. cit.*, p.67.

¹⁰² J. Strang, J. Sheridan and N. Barber, (1996) *op. cit.*, pp.270-272.

¹⁰³ J. Strang and J. Sheridan, 'Methadone prescribing to opiate addicts by private doctors: comparison with NHS practice in south east England', *Addiction*, 96 (2001), 567-576.

¹⁰⁴ Royal College of Psychiatrists and Royal College of Physicians, *Drugs, Dilemmas and Choices*, (London: Gaskell, 2000) pp.236-237.

¹⁰⁵ eg Doctor 010, Interview by Sarah Mars, (2000).

¹⁰⁶ A. D. Macfarlane, (1997) *op. cit.*

¹⁰⁷ A. Thorley, 'Clinical Guidelines Working Group (attached to CGWG(97)17 'Note by the Home Office on Licensing'), Home Office Licensing: The Options for Encouraging Good Clinical Practice', (8th May 1997), File 16 TFD-46 Vol. 5, DH Archive, Nelson, Lancashire.

expressed his concern about doctors failing to follow existing advice. Strang and Sheridan's 1995 national survey of community pharmacies found prescribing practices that did not observe earlier clinical guidelines and ACMD advice, to be widespread, pointing to the absence of any legal enforceability:

Daily dispensing and supervised consumption of methadone are the norm internationally. British guidelines recommending such practice¹⁰⁸ carry no statutory authority. No data have previously been presented on doctors' compliance with these guidelines. We find the option of daily dispensing to be widely disregarded, thus increasing known dangers of misuse and diversion to the black market.¹⁰⁹

¹⁰⁸ Department of Health, Scottish Office Home and Health Department and Welsh Office. *Drug Misuse and Dependence. Guidelines on Clinical Management*. (London: HMSO, 1991).

¹⁰⁹ Medical Working Group on Drug Dependence, *Guidelines of Good Practice in the Treatment of Drug Misuse* (London: Department of Health and Social Security, 1984).

¹¹⁰ ACMD, *AIDS and Drug Misuse: Update Report*. (London: HMSO, 1993).

Such moves seem not to have been aimed primarily at private prescribers, but would have addressed many of their practices that Professor Strang and the Drugs Inspectorate found unacceptable. A note from the '99 Guidelines Working Group's secretariat written towards the end of its lifetime, summed up the Group's intentions, describing

...a particular problem with inappropriate methadone prescribing leading to diversion onto the illicit market in a small number of private practices, particularly where practitioners work alone and where a majority of their work involves substitute prescribing for heroin and other drug misusers. The Working Group will be making particular recommendations to the Department of Health and the Home Office Drugs Inspectorate about how all practitioners who prescribe inappropriately might be more effectively monitored and controlled.¹¹⁰

Members of the AIP voiced concern at the prospect of licences for prescribing injectable methadone when they first heard of this in 1997,¹¹¹ and when the Home Office was attempting to implement the licensing proposals after its consultation exercise, some private doctors feared that it could be used to eradicate private prescribing. There were concerns that licences for injectables would be given only to psychiatrists working in DIDUs, as had been almost exclusively the case

¹⁰⁸ J. Strang, J. Sheridan and N. Barber, (1996) *op. cit.* 270-272.

¹⁰⁹ M. Davies, Memo to K. Jarvie, 'Drug Misuse Clinical Guidelines - Leak of Working Papers' (1st July 1998), File 16/DRU 323/22 Vol 1, DH Archive, Nelson, Lancashire.

¹¹⁰ AIP, (13th March 1997) *op. cit.*

with heroin and cocaine licences since 1968, and that daily dispensing and supervised consumption of methadone might be unaffordable for private patients compared with a weekly or fortnightly pick-up from a pharmacy as they would have to meet the cost of the additional dispensing fees themselves.^{111,112}

Anthony Thorley, the Department of Health senior medical officer and key member of the secretariat to the Working Group, briefly considered the possibility that private doctors might be excluded from injectable licences 'for not being able to fulfil the specialist criteria'. He had sketched the characteristics of a specialist doctor in an earlier working party document as including (though not requiring) the 'capacity to provide specialist support to generalists in shared care setting', 'active use of specialist professional inputs from a multidisciplinary team', 'fast turn around access to pathology and drug testing services' and 'use or provision of specialist treatment techniques: clinical psychology, counselling, etc.', all of which could be seen as outside the scope of most private doctors who often worked alone, outside the hospital setting and in isolation from medical colleagues.¹¹³ However, most of the considerations around licensing submitted to and produced by the Working Group seemed to have assumed that at least some private prescribers would apply for and receive licences.^{114,115,116} Furthermore, the '99 *Guidelines* even saw a role for private doctors in NHS shared care arrangements, recommending, 'Where there are no local specialist services with which a shared care agreement can be developed, it is the responsibility of the health authority to ensure that appropriate services are in place. This might mean, for example, developing a shared care arrangement with a service in the independent or private sector.'¹¹⁷ Such collaboration between private and NHS or voluntary sector services were not unheard of in the 1990s¹¹⁸ and characterised a blurring of boundaries between public and private.

A sub-group of the '99 Working Group was set up to consider private doctors in the licensing system and it reported two possible options: an equivalent requirement for private and NHS prescribing, and a stricter licensing requirement for private prescribing, to include oral methadone because, 'This recognises the fact that as this is a unique situation where, in particular, payment is

¹¹¹ Doctor 011, Interview by Sarah Mars, (2001).

¹¹² Doctor 005, Interview by Sarah Mars, (2000).

¹¹³ A. Thorley, CGWG (97) 5, 'Approaches to the definition of a specialist', (Feb 26th 1997), Private archive.

¹¹⁴ Department of Health, CGWG (97) 26, 'Private practice and the prescribing of controlled drugs', (June 1997), Private archive.

¹¹⁵ A. D. Macfarlane, (8th May 1997) *op. cit.*

¹¹⁶ Department of Health, 'Meeting to discuss Misuse of Drugs regulations and private practitioners', (June 1997) Private archive.

¹¹⁷ UK Health Departments, (1999) *op. cit.*, p.9.

¹¹⁸ M. Johnson, Interview by Sarah Mars, (2001).

received for a prescription of a controlled drug with potential financial advantages from long term prescribing, it therefore requires more comprehensive controls than the NHS'.¹¹⁹ Ultimately, the Working Group recommended additional controls for private doctors to prescribe oral methadone and they also endorsed the contemporary unwritten policy of Home Office Drugs Inspectorate restricting licences for cocaine, heroin and dipipanone to NHS prescribing.^{120,121}

The fate of the 1999 Guidelines licensing proposals

The principles of the licensing extension were proposed in 1999 by the Working Group in its report to ministers and the operational details were then drawn up by the Home Office Drugs Inspectorate and sent to a range of organisations for consultation.¹²² However five years on, the consultation had come to nought and the proposals had yet to be implemented.

In 1984 opposition to additional licensing from doctors guarding their clinical autonomy and the fear of deterring GPs from treating drug users may have played a part, and the same response was seen in 2001.^{123,124} Anthony Thorley's departure from the Department of Health in 1998, where he had been a strong advocate of the licensing system, may also have weakened the forward thrust of the policy. Michael Farrell, his replacement was 'more of a clinician than a civil servant and less interested in the regulatory side'.¹²⁵

The perceived need for licensing may have been lessened by the Royal College of General Practitioners establishing in 2001 a 'Certificate in the Management of Drug Misuse' to improve levels of training among their members. The threat of government regulation could have prompted this move to greater self-regulation. At the same time, the GMC had become very active in disciplining private prescribers, removing several from the medical register, which may have dimmed the sense of urgency for the Home Office to act.

Conclusions

If working by committee means that no one gets exactly what they want, the '99 Guidelines were a case in point, representing successes, accepted compromises and failures for their members. While

¹¹⁹ Department of Health, (June 1997) *op. cit.*

¹²⁰ Clinical Guidelines Working Group, 'Prescribing and Licensing Regulations' [attached to minutes of 16th March 1998], Department of Health, (1998) File 16/DRU 323/12 Vol 1, Department of Health Archive, Nelson, Lancashire.

¹²¹ A. Macfarlane, (17th March 2000) *op. cit.*

¹²² *Ibid.*

¹²³ eg. A. Banks, Letter to N. Fowler, MP, (1983), Ref 40117, DrugScope Library, London.

¹²⁴ eg. B. Beaumont, T. Carnworth, W. Clee, *et al.* (2001) *op. cit.*, p.25.

¹²⁵ L. Gruer, (2003) *op. cit.*

getting closer than ever before to the goal of extended licensing, by 2005 the Home Office's consultation document on its implementation was still just that. The apparent failure of the proposed licensing system could be attributed to similar forces to the attempts of the 1980s, namely the government's desire to re-engage primary care in the treatment of drug problems and GPs' defence of their clinical autonomy.

In addition, the 1999 threat of greater state regulation of doctors may have galvanised the Royal College of General Practitioners into setting up its training and accreditation, and so fulfilling some of the working group's training aspirations. As in the case of the GMC in Chapter 5, the profession under pressure from the state, this time accompanied by some of its own members, brought about an increase in its self-regulation.

Similar developments around Ireland's 1998 'Methadone Protocol' saw the successful introduction of licensing of GPs to prescribe methadone and an increase in GP participation.¹²⁶ The Irish licenses required GPs only to prescribe substitute drugs for opiate dependent patients with the support of specialist services, but while many circumstances bore striking resemblances to the English situation, the offer of a lucrative payment scheme to the licensed doctors, something for which the UK's General Medical Services Committee had been campaigning, may have provided the significant difference in gaining doctors' support.

During its deliberations, the Working Group saw movement back and forth between the range of prescribing that was considered suitable for primary care and the extent of any safeguards this required. A portion of the GP members seemed to be the main advocates of greater autonomy and less central control, showing more trust in their own judgement and their patients, while those directly employed by the state, such as the psychiatrists and public health physicians, put their trust in central government and those doctors who, like themselves, had received more extensive formal training. Indeed, most of the operational details, including who exactly would make the decision of whether to award a licence, were entrusted to the Home Office Drugs Inspectorate to settle.

The prospect of greater regulation of prescribing was initially greatly assisted by the turnover of civil servants. Key figures in the Department of Health and the Home Office, who had been influential in the first guidelines and licensing debates, had since moved on. Bing Spear joined the Home Office Drugs Inspectorate in 1952, becoming its Chief in 1977 but his ill health had compelled him

¹²⁶ S. Butler, 'The making of the Methadone Protocol: the Irish system?', *Drugs: Education, Prevention and Policy*, 2002, 9(4): 311-324.

to retire in 1986. Dr Dorothy Black, a consultant psychiatrist who had headed a drugs clinic in Sheffield, left her post as senior medical officer responsible for drugs and alcohol at the DHSS at the end of the 1980s. Bing Spear had been wary of handing too much control to the powerful London consultant psychiatrists and, along with Dorothy Black, was against extending licensing in 1984 (see Chapter 4).^{127,128} By 1997, when the idea was being reconsidered, Thorley and Macfarlane had taken their places. Unlike Spear, who was well known for his personal interest in the welfare of drug users, and doctors' clinical autonomy, Macfarlane's interest was more heavily weighted towards controlling the drugs supply, and the prevention of diversion, and less to the provision of treatment.

Neither patients nor private prescribers were invited onto the '99 working group, although some of its policies were directed at each, perhaps revealing that those selecting the membership saw them as requiring regulation rather than consultation. The absence of consumerist influences in this part of the NHS compared with other areas of health services, including the production of mental health guidelines, was notable here. The potential for conflict that these absences removed may have made the meetings run more smoothly, but other, perhaps less grave fault lines emerged.

The expansion of geographical representation to include for the first time Northern Ireland emphasised the divergence of prescribing traditions across the nation, including differences between Scotland and the South East of England. Divisions between public health or drug control issues on the one hand and individual health concerns on the other, a long running theme, emerged here once more, but not along a Home Office/Department of Health split. Indeed, the two departments were allied in their attempts to control prescribing outside the Clinics, and those psychiatrists in favour also benefited from support from the new addition of public health doctors.

Despite the fact that the '99 *Guidelines* inserted the term 'evidence-based' into the text on several occasions, and referenced many more research studies than the previous two editions, they were also frank that this was not the sole determinant of policy, being 'primarily based' upon expert committee reports and the 'clinical experience of respected authorities'. In this the *Guidelines* followed the tradition of the previous editions and of other expert committees in the drugs field. Evidence also seemed to be used rather unevenly. While the section on methadone maintenance, which was encouraged by the *Guidelines*, was given several references to research and evidence reviews, more sensitive topics such as heroin prescribing which the *Guidelines* seemed to be trying to

¹²⁷ Senior Civil Servant, DHSS, Interview by Sarah Mars, (2001).

¹²⁸ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.279-283.

deter, had no references at all. Although methadone maintenance could boast a much larger evidence base, a large scale, well-publicised and respected clinical trial of heroin prescribing had also been recently carried out but was not mentioned.

The policy-making process of the working group bore similarities to the old style of behind-the-scenes doctor and civil servant negotiations of the 1960s and '70s, particularly with the licensing proposals. However, the leak of confidential Working Party papers to the medical and drugs policy press went against the 'gentlemanly' code of private policy-making. Although it breached the agreed secrecy of the group, the leak may have been tolerated because it did not bring out these drug policy debates out into the general, public media but only to the drugs field. Alternatively, the chairman and secretariat might simply have been in the dark about who was the culprit.

The *'99 Guidelines* appeared to endorse a more liberal approach to prescribing, for instance with its recommendations for methadone maintenance in primary care and cautious recognition of injectable and amphetamine prescribing, but they maintained a restrictive view of who was qualified to carry out this work, and proposed additional controls such as supervised consumption. The *'99 Guidelines* and accompanying recommendations to ministers fell more toward increasing the state regulation and control of those working outside the Clinics, and consequently of the patients, and reducing autonomy than the previous edition. However, just as in 1984, the failure of the licensing proposals greatly weakened their intended impact.

In contrast to previous guidelines, the larger number of participating GPs and their strengthened position both in drug treatment policy and in the NHS more broadly were reflected in the concept of the 'specialised generalist', a GP with additional experience and training, capable of treating more complex cases outside the Clinic system, and in the idea that doctors outside the hospitals could be specialists too.

The wider geographical spread of services and reduced prominence of the London prescribing scene in treatment policy debates strengthened voices from outside the metropolis and reduced the concentration on private prescribing issues. This worked both for and against the interests of private prescribers: less attention was given to controlling their prescribing practices than was the case in the 1980s, but their scope for representation and participation in the policy process was also diminished. Instead, some of the GP members, who although not necessarily in favour of private prescribing per se, shared many of their interests and fears, acted as proxies for private prescribing on the Working Group, mitigating the centralising urges of other members.

Chapter 8

Organisation and Representation:

Three Professional Groupings

Introduction

The GMC, the Home Office Drugs Inspectorate, and the working parties which produced the clinical guidelines for the treatment of drug misuse all form part of the formal regulatory apparatus around prescribing controlled drugs, representing both state sponsored self-regulation and direct regulation by the state. This chapter considers three less formal mechanisms of self-regulation developed by the London Clinic doctors, the private prescribers and NHS general practitioners. These are the Association of Independent Doctors in Addiction (1981-1988), the Association of Independent Prescribers (1996-98) and the London Consultants Group (1968 to the present). By comparing the history of these three groupings, I hope to show how and why the London consultants succeeded in fending off outside regulation, and set the standards by which other doctors were judged, while the private doctors succumbed to extensive discipline.

The documentary sources for this chapter have been the committee papers and associated correspondence of AIDA and the AIP. Those of AIDA were deposited by Dr Dally at the Wellcome Library for the History and Understanding of Medicine, while one of the founders of the AIP gave the author access to the Association's papers. Documents from the London Consultants' Group have been much more elusive. A single document published in the journal *Addiction* claimed that the Department of Health, which originally provided the secretariat for the group, had not kept copies of the minutes. The secretariat was later provided by St George's Hospital, but they too denied having kept any minutes. A number of documents were then found by a member of the group, but access to them was denied by its 2003 membership on the grounds that the meetings were private. However, a small number of early minutes of meetings held at the Ministry of Health and DHSS written by civil servants had already been shared with the author. Interviews were also conducted with members of all three groups and civil servants from the Department of Health and Home Office.

Origins

The earliest grouping was that of the London Clinics consultants, brought together in 1968 by the Ministry of Health¹ when the new Clinics they headed were set up. The Regional Health Authorities were intended to take on these formal meetings after 1974 but never did so.² In the early 1970s, the consultants broke away from the Department of Health, and after a period of homelessness, during which they rotated between hospital sites, moved to the Home Office in 1977 at the invitation of Bing Spear, then Deputy Chief Inspector at the Drugs Branch.^{3,4} Running in parallel, at least for some of this period, were informal and exclusively clinical meetings, initially hosted by St Bartholomew's Hospital and held during the evenings.⁵ Both informal and formal groupings are referred to collectively as the 'London Consultants Group' or LCG, as they shared a great deal of business, membership and perceived identity. Indeed members of the groups give conflicting accounts as to which meetings were which.⁶

The formal LCG, called together by Ministry of Health, was initially chaired and minuted by Dr Alex Baker, a medical civil servant,⁷ and held in London. According to one member, 'the idea was there that policies would be determined.'⁸ The LCG's meetings at the Ministry of Health followed on from central government's direct rule over the Clinics, a result of the funding arrangements for London teaching hospitals that bypassed the Regional Health Authorities, although this later changed. Meetings seem to have been held initially about every month, attended also by DHSS and Home Office Drugs Branch staff.⁹

The informal meetings, in the absence of civil servants, were more relaxed and 'a place where we all got together and sort of said "Well my patients are worse than yours."¹⁰ Membership of both were restricted to the London area, where most of the Clinics were situated in 1968. Later on groups were formed, with Home Office Inspectorate involvement, to encompass treatment centres in the rest of Britain corresponding roughly with the Inspectorate's own regional divisions.¹¹

¹ The Ministry of Health became the Department of Health and Social Security in November 1968.

² H. B. Spear (and ed. J. Mott), *Heroin Addiction Care and Control: The 'British System' 1916-1984* (J. Mott (ed.), London: Drugscope, 2002) p.286.

³ J. Mack, Interview by Sarah Mars, (2003).

⁴ H. B. Spear (and ed. J. Mott), (2002) *op. cit.* p.243.

⁵ 'Meeting of doctors working in drug dependency treatment units in London, 20th January 1970 at St Bartholomew's Hospital', [fragment] Private archive.

⁶ See J. Willis, Interview by Sarah Mars, (2003); M. Mitcheson, Interview by Sarah Mars, (2003); J. Mack, (2003) *op. cit.*

⁷ T. Bewley, Interview by Sarah Mars, (2001).

⁸ J. Willis, (2003) *op. cit.*

⁹ DHSS, 'Drug dependence: clinical conference', [Minutes of meeting] (28th November 1968), Private archive.

¹⁰ J. Willis, (2003) *op. cit.*

¹¹ M. Mitcheson, (2003) *op. cit.*

For most of the 1970s, Clinics' policies were relatively uncontested, treating small numbers of addicts receiving substitute drugs. However, when the Clinics began to change their policies to ones less appealing to patients, doctors found drug users seeking supplies from the private sector or NHS GPs. New doctors outside the Clinics became involved, including the outspoken Dr Ann Dally, the Oxford educated private doctor working in Devonshire Place, near Harley Street. Dr Dally started AIDA in November 1981, with encouragement from Bing Spear, who initially allowed the group to convene at the Home Office,¹² until they were forced to move to Dr Dally's flat in Devonshire Place.¹³ Unlike the formal LCG, this state involvement was much more discrete and tentative. As an 'impartial' civil servant, Spear had to be careful of being seen to give endorsement to any group, particularly one which aroused the hostility of the London consultants. He later defended his role, saying that while the London consultants were hostile to the Drugs Inspectorate's contact with AIDA and the private prescribers, 'That contact was perfectly consistent with our long-established policy of keeping in contact with anyone working in the drug dependence field. It did not imply approval, or disapproval, of the clinical judgement of those concerned.'¹⁴

The 'independent' of the title was a self-proclaimed descriptor of doctors working outside the Clinics, both as NHS GPs and private psychiatrists. This was a significant distinction, as doctors inside and outside the Clinics had different prescribing privileges, and doctors outside had been discouraged from involvement in the treatment of addiction until official policy changed after the 1982 *Treatment and Rehabilitation* report (see Chapter 3). It was a division perceived by doctors on both sides of the divide, and *Treatment and Rehabilitation*, to which four NHS psychiatrists contributed, addressed prescribing in terms of doctors inside and outside the Clinics.¹⁵

The AIP also came together with encouragement from the state in its local form, this time through Kensington and Chelsea and Westminster Health Authority (KCWHA) and in response to grass roots concerns about diverted pharmaceuticals, which was coincidental to a move by private doctors and their allies to defend themselves in the face of adverse publicity.^{16,17} The original meeting from which it developed had been called by KCWHA and organised by Siwan Lloyd Hayward, then project manager for Westminster Drug Action Team, representing local services

¹² A. Dally, *A Doctor's Story* (London: Macmillan, 1990) p.85.

¹³ *Ibid.* pp.85-86.

¹⁴ H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.287.

¹⁵ ACMD, *Treatment and Rehabilitation*, DHSS (London: HMSO, 1982) pp.51-62.

¹⁶ S. L. Hayward, Interview by Sarah Mars, (2003).

¹⁷ M. Johnson, Interview by Sarah Mars, (2001).

and interests, with encouragement from public health director Dr Sally Hargreaves. It included representatives invited from the Home Office and Department of Health, medical and pharmaceutical professional regulatory bodies, local councillors, police officers, social services representatives and residents of areas concerned about the street dealing.¹⁸ Dr Matthew Johnson, part NHS GP and part private prescriber, Michael Audreson, Practice Manager at the private Hanway Clinic, and Gary Sutton, a private patient and activist, were instrumental, but the AIP proved to be the shortest lived and the least influential of the three groups.

Initially an association of private doctors, it widened its borders to encompass other clinicians involved in treating drug users 'since common ground in respect to the treatment of patients should form the criteria for membership.'¹⁹ What was the Association of Independent Prescribers in 1997, by the following year had become 'The Association of Independent Practitioners in the Treatment of Substance Misuse', presumably to reflect more accurately this multi-disciplinary membership. This expansion would suggest that although most of their activities were aimed at the regulation of private prescribing, an important defining factor was not only the sector in which members worked, but, like AIDA before it, a belief in the value of maintenance prescribing to addicts and in their differences from the NHS Clinics.^{20,21,22} Its declared aims were

- a) 'To define, describe and support prescribing outside traditional NHS drug dependency unit standards.
- b) 'To set up positive communication between practices.
- c) 'To develop self defence policy in case of problems with GMC or Home Office.'²³

The multi-disciplinary, but above all non-NHS Clinic membership, also reflected a reality of private practice in the 1990s, which far from a discrete sector, had many ties with the voluntary and statutory sectors. Matthew Johnson, for instance, worked in both as an NHS GP and private doctor. He received referrals from an NHS drug dependency unit and prior to that, from a voluntary sector project in north London.²⁴

¹⁸ 'Private Prescribing and Community Safety', [Minutes of meeting] (29th August 1996), Private archive.

¹⁹ AIP, 'Minutes of second meeting regarding prescribing and treatment for drug users', [Minutes of meeting] (23rd January 1997), Private archive.

²⁰ C. Brewer, Interview by Sarah Mars, (2003).

²¹ D. Samways, Letter to A. Dally, (9th August 1982), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

²² AIP, 'AIP proposed guidelines, 2nd Draft', (31st July 1997), Private archive.

²³ AIP, 'Regarding prescribing and treatment for drug users' [Minutes of meeting] (13th March 1997), Private archive.

²⁴ M. Johnson, (2000) *op. cit.*

Purpose

AIDA's purpose in the beginning was to raise standards among doctors working outside the Clinics, share information and campaign for policy changes. At its first meeting at the Home Office, the group's stated self-regulatory intention was 'to define accepted standards of practice'.²⁵ In the following year, it developed rules for its members and then expelled a Dr Rai for apparently failing to follow them.²⁶

There was considerable concern at the time that *Diconal*, a preparation of the opiate dipipanone and the anti-nausea drug cyclizine, was being prescribed in tablet form and crushed and injected with dangerous results.²⁷ AIDA decided that *Diconal* should be prescribed only in exceptional circumstance. Dr Rai, who was accused of persistently prescribing the drug, protested that he had changed nearly all his *Diconal* patients over to other medications and felt 'rather hurt' as he had 'tried at all times to comply with the wishes of the Association',²⁸ but the Association seems not to have relented. That same year Dr Dally, its president, admitted that she was still prescribing the drug herself: 'For a long time I have pressed and campaigned for the prescribing of *Diconal* to be restricted. I treat only four *Diconal* addicts. One of them will be off this drug within a week or two. One has never had any other drug than *Diconal* and is therefore a "pure" *Diconal* addict.'²⁹

Similar inconsistencies happened within the London Clinics, where some long term patients continued to receive heroin and injectable methadone in the 1980s after the Clinics had moved away from such prescribing, but without the regulatory consequences that afflicted Dr Dally. In 1983, Dr Dally was brought before the Professional Conduct Committee of the GMC for her *Diconal* prescribing (see Chapter 5).

AIDA's ambitious and confident aspirations to shape events perhaps reflected the sense in the 1980s that this was a crucial transitional period. Some of the biggest changes in the scale and nature of England's drug use, and particularly opiate consumption, happened during this time. Heroin smoking, previously unseen in England, became popular, a huge black market developed where

²⁵ AIDA, 'Notes of first meeting, Tuesday 24th November, 1981', (January, 1982), File PP/DAL/B/1/1/2, Wellcome Library, London.

²⁶ A. Dally, Letter to Dr D. D. P. Rai, (17th January 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

²⁷ GMC, Professional Conduct Committee, Day Two, (6th July 1983), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London. pp.2/55-2/57.

²⁸ D. D. P. Rai, Letter to A. Dally, (30th January 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

²⁹ A. Dally, Letter to S. Perrins, (7th March 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

previously most users had taken the overflow from doctors' prescriptions, much larger numbers of users were turning up for treatment, and the Clinics were inundated (see Chapter 2). Significant numbers of doctors outside the Clinics were being drawn into the field for the first time since the 1960s, and in the mid-1980s HIV/AIDS emerged to change the picture further.

The LCG's original aims included mutual support and sharing useful information. Thomas Bewley, consultant at the Tooting Bec Hospital Clinic recalled them as 'rather jolly meetings', and that DDU psychiatrists tended to be rather isolated, especially within psychiatry where they were already looked down on by other doctors.³⁰ 'This need to discuss the work they were undertaking resulted partly from the sense of experimentation and uncertainty detectable in the early years of the Clinics. Before treatment allegiances solidified, many types of prescribing were tried out, including amphetamines and cocaine, which were later abandoned. Prior to a clinical trial of oral methadone and injectable heroin carried out by Martin Mitcheson and Richard Hartnoll at University College Hospital Drug Dependency Unit, between 1967 and 1974 preferences for oral methadone had yet to coalesce and a DDU nurse recalled

We actually prescribed all kinds of drugs; it was almost like a kind of oriental bazaar. People would come from far and wide to the Clinic and they would actually say "We are using three or four or five grains³¹ of berwin" and the doctor would say "No, no, no, that's too much, but we give you three, and if you can't manage, we give you some physeptone [methadone] ampoules, and if you can't go to sleep, we give you some barbiturates and if you can't wake up, we give you some amphetamines." It was this kind of bargaining at the beginning, until Dr Mitcheson had the research going.³²

Dr Bewley, who attended LCG meetings until his retirement in 1988 concurred: 'No one had the faintest idea of what they were doing [at the Clinics] and were all expected to solve the problem of drug dependence, so it helped to swap notes.'³³ Practical matters, such as useful innovations in drug formulations were put forward. A formulation of methadone mixture including blackcurrant syrup developed by Dale Beckett, was discussed, as the blackcurrant would apparently show up in patients' urine to show whether they had consumed the drug as prescribed.^{34, 35} This later became the accepted basis of the oral methadone formulation.³⁶

³⁰ T. Bewley, (2001) *op. cit.*

³¹ Prior to British Pharmacopoeias' standardised to metric measures in 1968, the 'grain' was the lowest measure of weight in the Apothecaries system equivalent to just under 65 milligrams.

³² M. Sharpe, Interview by Sarah Mars, (2001).

³³ T. Bewley, (2001) *op. cit.*

³⁴ H. D. Beckett, Interview by Sarah Mars, (2001).

According to one member, there was an awareness of prescribed dose differentials between the different Clinics from the beginning of the DHSS meetings, and a peer pressure on keeping them low.³⁷ The influence of the Second Brain Report, and its concerns to curb the development of a market in diverted pharmaceuticals could be seen here.

The formal LCG meetings also provided an opportunity to share information with civil servants about forthcoming legislation, providing informal consultation with the doctors.^{38,39} At one meeting, the Home Office's representative Mr Beedle 'agreed to consider the possibility of the early introduction of regulations under the 1967 Dangerous Drugs Act restricting the prescribing of methadone.'⁴⁰

The AIP had narrower ambitions than AIDA, perhaps reflecting the more stable policy period of the mid-1990s. Furthermore, its origins in the complaints of a number of regulatory bodies and concerned parties, was based partly in a need for self-defence, meaning that it was more concerned with changing the behaviour of its members and communicating these changes than with wider drugs policies. Like AIDA, it also expelled members, partly because it needed a sanction by which to enforce its standards, but also because some members felt tainted by association with particular prescribers and threatened to withdraw if this action was not taken.⁴¹

Both the AIP and AIDA meetings admitted to poor standards among some of their members, with particular concerns about financial motivations. Discussing the possible new clinical guidelines from the Department of Health at a meeting of the AIP, Dr Brewer conceded, 'the essence of the problem was due to some private doctors increasing their patient loads to increase their financial gain and this could be the main motivation for treatment'.⁴² Dr Beckett recalled his concerns about some of his fellow private prescribers: 'I remember that I used to go up to London to [Ann Dally's] consulting room, to her flat at the top of her house every so often and meet with other doctors who were prescribing because it was a worry really. A lot of doctors didn't seem to

³⁷ DHSS, 'Heroin dependence: clinical conference, 1st December 1969', [Minutes of meeting], (January 1970), Private archive.

³⁸ H. B. Spear, (2002) *op. cit.*, p.236.

³⁹ M. Mitcheson, 'Drug clinics in the 1970s' in J. Strang and M. Gossop (eds.), *Heroin Addiction and Drug Policy: The British System* (Oxford, New York and Tokyo: Oxford University Press, 1994) pp.178-191.

⁴⁰ M. Mitcheson, (2003) *op. cit.*

⁴¹ DHSS, 'Heroin dependence: clinical conference', [Minutes of meeting] (18th September 1969), Private archive.

⁴² *Ibid.*

⁴³ M. Johnson, (2001) *op. cit.*

⁴⁴ AIP, (13th March 1997) *op. cit.*

be doing right by their patients – giving them enormous prescriptions, extraordinary, and raking the money in – it was ghastly.⁴³

Organisation and Structure of the Groups

Working in independent small businesses, private doctors could be characterised as entrepreneurs. This term refers to their forms of organisation, ways of working and belief systems, but does not imply that profit was their main motive. In Cultural Theory terms, such individuals have been described as practising in a context dominated by competitive conditions, control over other people and individual autonomy, and where the definitions and boundaries through which they related to the world were weakly drawn and flexible.⁴⁴ As independent contractors general practitioners shared some of these characteristics, but with their greater dependence upon a single client, the National Health Service, had less autonomy and were less competitive among themselves. AIDA's structure and experiences reflected these characteristics.

Throughout its lifetime, AIDA's forward thrust was powered by a single charismatic leader, rather than shared among equally motivated members. Dr Dally, as AIDA's first and only president, seems to have chaired most of the meetings, and undertaken the largest part of the work arising, such as writing letters and policy documents. When her involvement and interest in the drugs field came to an end, there was no one to replace her.

Dr Dally's ability to network, a characteristic of the successful entrepreneur, was largely behind AIDA's high profile, given its small membership and the hostility of the opposition. She had Oxford University connections with one member, Dr Susan Openshaw, and also with Mrs Thatcher, then Prime Minister, which she used to lobby for her own and AIDA's cases. She took an opportunistic approach to recruitment, inviting diverse people to join who shared her viewpoint, such as American academic Arnold Trebach. As might be expected of a small organisation with limited resources, the secretariat was provided in-house by Dr Dally.

Its purpose also largely reflected Dr Dally's concerns. At the outset she gained considerable publicity for AIDA, with announcements on the BBC's six o'clock news and in a number of medical journals. She campaigned for changes to the Clinics' approach to prescribing, changes to the law, and for greater involvement in prescribing by doctors outside the Clinics.

⁴³ H. D. Beckett, (2001) *op. cit.*

⁴⁴ M. Douglas, *Cultural Bias*, Occasional Paper No.35 (London: Royal Anthropological Institute, first published 1978, second impression 1979) p.21.

Its degree of formal organisation seems to have diminished, starting out with both a president and a secretary and a working group set up to draft its own guidelines. As time went on there was a merging of her own personal difficulties with the GMC with the wider concerns of her colleagues, partly as a result of her view that the personal was political in this case,⁴⁵ and partly because of her dominant role in what became a relatively unstructured organisation. By the end of its life in 1987/88, Dr Colin Brewer described the Association as a support group for Dr Dally 'in her time of trial'.⁴⁶ He recollected no regulatory role or intentions in the late 1980s. By 1987 AIDA was unstructured with no committee. Eventually the Association folded 'for lack of interest'.⁴⁷

Like AIDA, the AIP was a small organisation whose secretariat was provided by the administrative staff of one of the member organisations – the Hanway Clinic – and which had little internal structure. The Association also functioned as the first register of doctors providing private treatment to drug users. This was achieved by Dr Johnson, the leading doctor involved in establishing the AIP, Michael Audreson, practice manager at the Hanway Clinic, and Gary Sutton, a patient and drug user activist, pooling their knowledge for invitations to the first meeting, talking to other private prescribers and to pharmacists.⁴⁸ They limited their scope to doctors with significant involvement in the area, rather than those with one or two drug using patients on the grounds that they would have been harder to find and probably less committed.⁴⁹ The lack of any such register prior to this reflected, in contrast to the NHS, the lack of a central bureaucracy employing doctors in this field, and little economic impetus to group together. Having said this, data held by the Ministry of Health or DHSS on the existence of NHS drug clinics was more than once found to be inaccurate.⁵⁰ In addition, some doctors had been wary about publicising their services for fear of being inundated by addict patients seeking prescriptions.⁵¹

Just as the entrepreneurial character of the 'independent' doctors revealed itself in the organisations they developed, so it was with the London Consultants. These doctors worked within the hierarchy of hospital medicine with the NHS as employer. They shared a strong sense of identity as a group, perhaps partly engendered by their lowly status within psychiatry, and consequently drew themselves inside a boundary against outsiders. They were also motivated by a desire to keep at bay government involvement in what they saw as clinical decisions.

⁴⁵ See Ann Dally's description of the cases in *A Doctor's Story*, (London: Macmillan, 1990) pp.99-281.

⁴⁶ C. Brewer, Interview by Sarah Mars, (2003).

⁴⁷ C. Brewer, Letter to A. Dally, (27th June 1988), File PP/DAL/B/4/1/1/1 (File 2 of 2), Wellcome Library, London.

⁴⁸ M. Johnson, (2001) *op. cit.*

⁴⁹ *Ibid.*

⁵⁰ See H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.151-176 and ACMD, (1982) *op. cit.*, pp.97-102.

⁵¹ eg M. Johnson, (2000) *op. cit.*

While not competing for fees or patients, they were to some extent rivals for prestige and resources, but steps were taken to minimise competitive behaviour in the interests of the group. For instance, the rivalry between Philip Connell, Director of the Maudsley Hospital's drug treatment unit, and Griffith Edwards, Director of the Addiction Research Unit at the Institute of Psychiatry, was not allowed to prevent the group from sending a letter of congratulations when Edwards was awarded an academic chair.⁵² Furthermore, to ensure that no one individual gained too much power over the group, the role of chair revolved between members. Likewise after a period during which the meetings had been held at the workplaces of members in the 1970s, the Home Office was taken up as a permanent venue when offered, as it was geographically central and 'neutral ground' not being the base of any particular consultant.⁵³ The allocation of tasks according to rank is also typical of hierarchy.⁵⁴ According to Dr Martin Mitcheson, the most senior members or 'elder statesmen' Drs Connell and Bewley were deputed to visit Dr Dally to discuss with her the group's concerns about her practice.⁵⁵

The fight to guard clinical autonomy emerged early on. The secretariat and chair for the formal LCG was initially provided by the Department of Health's Dr Alex Baker and in his minutes of the first meetings recorded, erroneously according to Dr Bewley, that they had all agreed to reduce their prescribed doses of heroin: 'There was general acceptance that complete uniformity in prescribing practice was impossible. It was agreed however that, as a general guide, each clinic should seek to reduce progressively the total quantity of heroin prescribed.'⁵⁶

Thomas Bewley objected, seeing this as Dr Baker putting in his own opinion which had not been discussed.⁵⁷ Philip Connell had already expressed the desirability of the Clinics cutting down their doses through concerted action, '...it is necessary to recognise that there is a need to cut down the dose of drugs already being prescribed to addicts. This could best be effected by agreement by those working in the treatment centres that when they are working smoothly and preferably on an appointed day all clinics will reduce the amount of heroin prescribed over a period of, say a month to about half.'⁵⁸

⁵² J. Mack, (2003) *op. cit.*

⁵³ *Ibid.*

⁵⁴ M. Douglas, (1979) *op. cit.*, p.20.

⁵⁵ M. Mitcheson, (2003) *op. cit.*

⁵⁶ DHSS, [Minutes of meeting held on 28th November 1968] *op. cit.*

⁵⁷ T. H. Bewley, (2001) *op. cit.*

⁵⁸ P. H. Connell, 'Drug dependence in Great Britain: a challenge to the practice of medicine' in H. Steinberg (ed.), *Scientific Basis of Drug Dependence* (London: J&A Churchill, 1969) pp.291-299, p.297.

And although soon after this became the group's own policy, it may have been the government source of the proposal that made it unacceptable in the minutes of that first meeting. A struggle for control then developed between the Department of Health and the doctors, with the doctors victorious. Early in the 1970s they wrote a letter telling the Department of Health that they wished to break away and form their own independent group.⁵⁹ They were later offered rooms by the Home Office, where they remained. John Mack, consultant in Hackney DDU and the longest serving member of the group, expressed the consultants' determination for independence of government. 'At the very early meetings we wanted to make it quite clear that they were our meetings, they were not Department of Health meetings. We were happy for the senior medical officer from the Department of Health to be there and Bing Spear to be there, but we wanted them to be our meetings, not official meetings.'⁶⁰

Some years later, in the late 1970s or early 1980s, another small battle took place, as one member recalled, 'There was a bit of an awkward scene from one time...Dorothy Black was Senior Medical Officer [at the Department of Health] and she was from outside London and she came to the meeting and she tried to take it over and she had to be quite rudely told that it was not her meeting, that she was the Senior Medical Officer at the Department of Health being invited to our meeting.'⁶¹ At the same time, the informal LCG meetings took place in the evenings at medical venues without any civil servants, but included discussion of points raised at the formal DHSS meetings, and agreed points to feed back to the DHSS secretariat.⁶²

Membership and critical mass

A problem afflicting both AIDA and the AIP was falling membership. Dr Dally described the first AIDA meeting as well attended:

The meeting was organised by myself after talking particularly to Dr A. W. Beard (Consultant Psychiatrist, Middlessex Hospital). Apart from us there were some psychiatrists in private practice, eg Dr Anthony Flood and Dr Michael a Brook, and some NHS GPs (such as Dr Margaret McNaire, Dr Tessa Hare, Dr Susan Openshaw and Dr R Robertson). The meeting was held at the Home Office and altogether there were about 16 doctors, also

⁵⁹ J. Mack, (2003) *op. cit.*

⁶⁰ *Ibid.*

⁶¹ J. Mack, (2003) *op. cit.*

⁶² 'Meeting of doctors working in drug dependency treatment units in London, 20th January 1970 at St Bartholomew's Hospital', *op. cit.*

*Byng [sic] Spear, the Chief Drug Inspector at the Home Office, one of the other Inspectors, Ian Heaton, and Dr Dorothy Black from the DHSS.*⁶³

But after that, numbers seem to have diminished, with attendance at meetings generally only three or four.^{64,65} Its president remarked in December 1982, 'I can't say that we are inundated with applications for membership'.⁶⁶ The cost of membership in 1986 was £25 a year. At this stage they were meeting 'every few weeks'.⁶⁷

The AIP also started with wider enthusiasm than it managed to maintain, and in a bid to set standards of practice, expelled the two members thought to be most problematic. Matthew Johnson explained, 'We'll first of all we did throw a couple of people out of the group, who shall remain nameless. So...trouble is after that what was left wasn't a very big group and...then people stopped coming and...the group that was eventually left were people who had been abiding, who had been well within the guidelines that had been set anyway, originally'.⁶⁸

Views and policies of the groups

Key differences revealed by the three groups' policies were not only their content but their ability to reach and implement agreements. Although the focus of AIDA varied over the years, Dr Dally's essential message remained the same. Her own and AIDA's professed policies were that:

- (i) 'the proper person to treat an addict [was] his or her own GP or a doctor to whom that GP has referred him or her'.⁶⁹
- (ii) Long term prescribing was necessary to allow stable addicts to maintain a law-abiding lifestyle, and the policy of the Clinics offering only short term prescribing and detoxification was forcing such addicts onto the black market to obtain a drug supply.⁷⁰
- (iii) That NHS treatment was the ideal, but that until it was provided in a manner more acceptable to patients, private practice would continue to be necessary.⁷¹ [AIDA tried

⁶³ A. Dally, Letter to I. Munro, (3rd December 1981), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

⁶⁴ C. Brewer, (2003) *op. cit.*

⁶⁵ H. D. Beckett, (2001) *op. cit.*

⁶⁶ A. Dally, Letter to A. Trebach, (3rd December 1982), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

⁶⁷ A. Dally, Letter to Dr A P Gray, (21st November 1986), File PP/DAL/B/4/1/1/1 (File 2 of 2), Wellcome Library, London.

⁶⁸ M. Johnson, (2000) *op. cit.*

⁶⁹ A. Dally, Letter to the Editor, *GP Magazine*, (8th April 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

⁷⁰ A. Dally, Letter to The Guardian newspaper, (8th April 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

unsuccessfully to set up a non-profit clinic for those unable to afford private fees, and applied for funding under the Central Funding Initiative of 1983.]

- (iv) That prescribing injectable methadone had therapeutic value.
- (v) That *Diconal* should only be prescribed in exceptional cases.⁷²
- (vi) That drug treatment should take into account the role played by the criminal black market in the drug supply.⁷³

Unlike AIDA, the AIP considered private treatment valuable in itself, rather than simply as a supplement where the NHS was inadequate, wishing to emphasise the fact that it did not burden the taxpayer and provided choice.⁷⁴ Like AIDA, it supported maintenance prescribing, including injectable methadone.

One of the spurs to the AIP's project in self-regulation was the anger and fear felt by residents of Sherland Road in west London towards the open street market in diverted prescribed drugs around Maguire's chemist⁷⁵ supplied by private prescribers. Diversion, it was admitted by the Association, was 'a reality' and 'the Achilles heel for private prescribing'.⁷⁶ This prompted a number of the AIP's policies, including the use of test dosages, where a patient took their first dose under the doctor's observation to ensure it was safe and that they were not asking for more drugs than they needed in order to sell on.⁷⁷ The AIP tried to produce guidelines laying out its policies, and although these allowed considerable latitude, such as not setting restrictions for how often patients should pick up their prescribed drugs, an area of contention throughout the period, the Association was unable to reach agreement and they remained, like AIDA's guidelines, forever in draft form.⁷⁸

The ICG's policies extended over the entire period under study, and changed during that time. Due to the denial of access to the minutes of the meetings, key policies are discussed here rather than a complete review. During the later 1970s and early 1980s, there was a spectrum of opinion about being more or less liberal in prescribing, but the majority seemed to follow Dr Bewley's view

⁷¹ A. Dally, Letter to I. Munro, (22nd January 1982), File PP/DAL/B/4/1/1/1 (file 1 of 2), Wellcome Library, London.

⁷² AIDA, 'Comments on: Department of Health and Social Security: Treatment and Rehabilitation (HMSO), 1982).

Report of the Advisory Council on the Misuse of Drugs' (January 1983), File PP/DAL/B/4/1/1/7, Wellcome Library, London.

⁷³ AIDA, 'AIDA Comments on "Guidelines of Good Clinical Practice in the Treatment of Drug Misuse" DHSS 1984 (July 1985)', File PP/DAL/B/4/1/1/8, Wellcome Library, London.

⁷⁴ AIP, 'Private Prescribing and Treatment for Drug Users.' [Minutes of meeting] (10th December 1996), Private archive.

⁷⁵ S. L. Hayward, (2003) *op. cit.*

⁷⁶ AIP, (10th December 1996) *op. cit.*

⁷⁷ *Ibid.*

⁷⁸ M. Johnson, (2000) *op. cit.*

that prescribing should be standardised to present a united front to patients, so the aim of the meeting was to try to synchronise practice.⁷⁹ There was disagreement over the prescribing of heroin and injectable drugs, but, as shown in Chapters 3 and 4, peer pressure successfully reduced heroin and injectable methadone prescribing in the 1970s and replaced it with oral methadone. The move away from prescribing injectable drugs, and methadone in particular, which took place in the late 1970s, was foreshadowed in an LCG meeting as far back as December 1969: 'Although it was agreed that methadone undoubtedly had some value in the treatment of heroin addiction there was disagreement about the extent to which it should be used, particularly in its injectable form.'⁸⁰

While AIDA and the AIP both attempted to develop guidelines with the aim of improving existing poor practice, the LCG seems to have produced guidelines early on with the aim of coordination. A document entitled 'Practical matters relating to the treatment of drug-dependent patients' was submitted by Dr Connell to a meeting in September 1969 at the Department of Health.⁸¹ This may have been the same document minuted as 'Principles of Treatment', about which 'the meeting accepted the value of a document on the lines of Dr Connell's paper' but 'there was some disagreement with specific points'. A further draft was to be presented to a future meeting incorporating amendments from the group.⁸² It is not clear whether the document published in *Addiction* in 1991 is the same one as that mentioned in the minutes, and if so, whether this was the revised version or the original.

At a meeting in 1969, the LCG determined to protect their prescribing expertise declaring that, 'The prescribing of methadone to addicts by general practitioners was unanimously condemned and it was agreed that a letter expressing this view to the medical press signed on behalf of those present as representing a body of authoritative medical opinion on drug dependence, might help to curb the practice.'⁸³

On a number of policy developments Drs Connell and Bewley dominated. As with Dr Dally, this may have partly rested on personal qualities – one member remarked 'Philip Connell could walk into this room right now and take over; that was Connell's style',⁸⁴ but a stronger source of power was their extensive involvement in medico-political life and the

⁷⁹ T. Bewley, (2001) *op. cit.*

⁸⁰ DHSS, (January 1970) *op. cit.*

⁸¹ P.H.Connell, 'Treatment of drug-dependent patients, 1968-1969', *British Journal of Addiction*, 86 (1991), 913-915.

⁸² DHSS, [Minutes of meeting held on 18th September 1969] *op. cit.*

⁸³ DHSS, (January 1970) *op. cit.*

⁸⁴ J. Willis, (2003) *op. cit.*

prestigious offices it yielded. Both were, at various times, members of the GMC and special advisors to the Chief Medical Officer; Dr Bewley became President of the Royal College of Psychiatrists and Dr Connell chaired the influential Advisory Council on the Misuse of Drugs.

The class system also seems to have been a strong influence in hospital medicine at least in the 1970s. Selection for consultant posts at St Bartholomew's consisted not only of the formal interview, but was preceded by a 'trial by sherry', essentially an informal drinks party at which the candidates were assessed,⁸⁵ with social experience and skill clearly playing a role. This hint at upper class, Oxbridgian preferences, is maintained by the note from an early informal LCG meeting, stating that an initial payment of five shillings would be charged 'to cover the cost of sherry for the meetings'.⁸⁶ The Home Office, by contrast, offered a more bourgeois tea and biscuits.

Successes and Failures

Internal Influence

Both the AIP and AIDA attempted to produce clinical guidelines for their own organisations and neither got beyond the drafting stage because of an inability to agree.^{87,88} According to the AIDA minutes, 'There was a good deal of discussion about the way in which patients should be assessed.' Dr Poncia, a private doctor 'felt that routine urine testing in all cases might be counter-productive. This highlighted a certain amount of disagreement about the clinical management of patient [sic] in which members agreed to differ.'⁸⁹

AIDA and the AIP's inability to agree on guidelines reflected, in part, the fact that doctors outside the NHS hospital setting may have chosen an 'independent' path because they did not like working to corporate policies, guidelines and protocols.⁹⁰ Furthermore, being to some extent in competition with each other for patients, they also had something to lose by working to the same patterns, particularly with the market sensitive issues of cost and dosage.

⁸⁵ J. Mack, (2003) *op. cit.*

⁸⁶ 'Meeting of doctors working in drug dependency treatment units in London, 20th January 1970 at St Bartholomew's Hospital', *op. cit.*

⁸⁷ AIDA, 'Drug Addiction: Guidelines and Standards in Management', Pre-publication edition., February 1982, File PP/DAL/B/4/1/1/5, Wellcome Library, London.

⁸⁸ AIP, (31st July 1997) *op. cit.*

⁸⁹ AIDA, 'Minutes of first meeting of the Working Party', (24th November, 1981), File PP/DAL/B/4/1/1/4, Wellcome Library, London.

⁹⁰ M. Johnson, (2001) *op. cit.*

Unlike the three editions of the official Department of Health guidelines,^{91,92,93} which chose to limit the discussion of controversial topics, such as heroin, stimulant and injectable prescribing, the AIP's draft guidelines focused on regulating existing controversial practices. While the Department of Health's documents were aimed partly at encouraging the participation of doctors not already treating drug users, the AIP's document was intended to tackle the aspects of treatment that were gaining negative publicity and regulatory attention for doctors already involved. Other aspects of private treatment, such as the use of clonidine and lofexidine in detoxification were used by some of the private doctors but were not in dispute and so went unmentioned.⁹⁴ Matthew Johnson also proposed that a prescribing limit of 200mg methadone be implemented between members, and 'There was a consensus of agreement that there could be an agreed upper limit, which all doctors involved in the group could work to,'⁹⁵ but it was never implemented. The AIP 'disintegrated in sort of people disagreeing too much we couldn't get proper consensus going.'⁹⁶

Although both the AIP and AIDA finally collapsed, Dr Johnson and Dr Dally both felt that they had had a positive impact on their members. Dr Dally claimed 'I am quite sure that some of the less ethical doctors have improved their ways as a result of membership',⁹⁷ and Dr Johnson, while frustrated with the process of disagreement and fragmentation, believed that by bringing people together, prescribed dose levels had been reduced, even among the two suspended doctors, although neither claim can be verified without further data.⁹⁸

External influence

AIDA focussed not only on changing practice among doctors, but also the view of the public and government. Ann Dally engaged in much media activity, including radio and television. She wrote letters to government and, with Dr Dale Beckett and Dr Tessa Hare, presented evidence to several committees. Articulate, intelligent and a good networker, Dr Dally had an impressive ability to gain the attention of influential individuals. She also benefited in this from promoting a consistent message, in which she held no doubts. However, this access and conviction did not bring with it influence. AIDA's position, although of interest to the media, expressed dissatisfaction with the

⁹¹ Medical Working Group on Drug Dependence, *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* (London: DHSS, 1984).

⁹² Department of Health, Scottish Office Home and Health Department and Welsh Office, *Drug Misuse and Dependence. Guidelines on Clinical Management*. (London: HMSO, 1991).

⁹³ UK Health Departments, *Drug Misuse and Dependence. Guidelines on Clinical Management*, (London: The Stationery Office, 1999).

⁹⁴ M. Johnson, (2001) *op. cit.*

⁹⁵ AIP, (10th December 1996) *op. cit.*

⁹⁶ M. Johnson, (2000) *op. cit.*

⁹⁷ A. Dally, (3rd December 1982) *op. cit.*

⁹⁸ M. Johnson, (2001) *op. cit.*

wider regulatory system of drug control in Britain, a view that, in the 1980s ruled it out of serious policy consideration.

Perhaps AIDA's biggest opportunity came when Prime Minister Margaret Thatcher, with whom Dr Dally had been at Somerville College, Oxford, invited her to discuss the drug problem at Number 10. Dr Dally visited Margaret Thatcher at Downing Street early in 1983 but failed to convince her of her position. Indeed she speculated later that this high profile meeting may have encouraged her opponents to construct the GMC case against her.⁹⁹ Although she received some warmly worded letters from the Prime Minister, Mrs Thatcher made no interventions on AIDA's behalf, writing, 'I know very well how deeply you feel about this. But I hope you will understand when I say that I think it would be wrong for me to comment on the disagreement between yourself and the Department of Health and Social Security. I have read every word of your letter – but I cannot judge who is right.'¹⁰⁰

AIDA, although maintaining a high profile for several years, achieved very little in influencing formal policy-making bodies. Chapter 4 showed how, although invited onto the 1984 DHSS good practice guidelines working group, AIDA's representatives Drs Dally and Beckett were sidelined and outmanoeuvred by London consultants Thomas Bewley and Philip Connell and the Secretariat. Although AIDA opposed the extension of licensing under which all doctors would have required Home Office permission to prescribe opiates, and was pleased to find that, after some delay, the proposal was dropped by government, AIDA's opposition was less likely to have been critical than that emanating from the Home Office and the additional government concern that the arrangement would require extra spending and risk alienating GPs (see Chapter 4).

AIDA was also invited to give oral evidence to the Social Services Committee's enquiry into the misuse of drugs in 1985. Here again, the role of the London NHS psychiatrists may have neutralised any positive impact, for the Committee's special advisor was Dr Martin Mitcheson, consultant in charge of University College Hospital's DIDU and a prominent member of the ICG, who took credit for inviting Dr Dally as a negative example. Dr Mitcheson claimed his strategy was successful, describing the committee as 'appalled' by Dr Dally,¹⁰¹ and its findings and recommendations would seem to support this. Sounding almost like a parrot trained by the London consultants, their report pressed for an extension of licensing to all injectable opiates, for

⁹⁹ A. Dally, (1990) *op. cit.*, pp.100-102.

¹⁰⁰ M. Thatcher, Letter to A. Dally, (7th June 1984), File PP/DAL/B/4/1/1/1 (File 2 of 2), Wellcome Library, London.

¹⁰¹ M. Mitcheson, (2003) *op. cit.*

licences to continue to be restricted to doctors working in or under the supervision of a consultant in a clinic, and for particular attention to be paid to restricting private doctors.¹¹²

During the AIP's short life, the group made only one attempt to influence an outside policy making body and failed. The Department of Health's guidelines working group, whose final output would be published in 1999, had already drawn up its membership and started meetings when the AIP met for the first time and proposed nominating (uninvited) Dr Colin Brewer as their representative.¹¹³ However, it seems unlikely, had they emerged earlier, that they would have gained access since relations were poor between Dr Brewer and the chairman Professor John Strang, who had skilfully made a nod in the direction of private sector representation by inviting the non-prescribing Dr David Curson. Perhaps if the AIP had established itself prior to the start of the Clinical Guidelines Working Group a representative would have been chosen for the sake of appearance, as occurred in 1984 with AIDA, but the need to be seen to be consulting this group of doctors was considerably less in the 1990s when they represented a far smaller proportion of the expanded drug treatment world, and neither were they the main advocates of maintenance prescribing.

The changes which followed the Second Brain Report, on which certain London psychiatrists who became Clinic consultants had been highly influential, had succeeded in handing over heroin prescribing and the medical treatment of drug users over to NHS consultant psychiatrists in 1968, and they clung keenly to their prescribing privileges over the next three decades. Their attempts, however, to extend their monopoly to other drugs of dependence were unsuccessful. This disappointed aspiration was first recorded at an informal ICG meeting in 1969, when, 'It was regretted that the suggestion that prescription of all dependency producing drugs to known addicts should be limited to treatment centres had been dropped by the Department of Health on grounds of cash.'¹¹⁴ After this came moves to own the prescribing of methadone or other opiates, and although gaining support from many influential bodies, such as the Social Security Committee, the ACMD and the Department of Health's 1999 Clinical Guidelines Working Group, the consultants remained unsuccessful here too (see Chapter 7).

¹¹² House of Commons Social Services Committee, *Misuse of Drugs with Special Reference to the Treatment and Rehabilitation of Misusers of Hard Drugs. Fourth Report of the Social Services Committee, Session 1984-85* (London: HMSO, 1985) pp.lvi-lvii.

¹¹³ AIP, (10th December 1996) *op. cit.*

¹¹⁴ J. L. Reed, "Meeting of Doctors Working in London Drug Dependency Treatment Centres, November 25th, 1969 at St Bartholomew's Hospital" [Minutes of meeting], Private Archive.

Aside from these disappointments, Dr Connell and Dr Bewley, the most politically active members of the LCG during the 1970s and early 1980s, achieved some successes in protecting the interests of the NHS Clinic psychiatrists and extending their discipline over outside doctors. Both were members of the ACMD's Treatment and Rehabilitation Working Group, and its report recommended a number of curbs on the prescribing of doctors outside the Clinics.¹⁰⁵ Although not all of these were implemented, the proposed good practice guidelines for doctors did become a reality in 1984. Dr Connell won the right to chair the committee responsible for the first guidelines, and John Strang, the most senior addiction clinician at London's Maudsley Hospital, chaired the second two in 1991 and 1999. Specific measures to protect the privileged position of NHS Clinic psychiatrists were included in both the 1984 clinical guidelines and the 1999 re-write,^{106,107} and both were used in disciplinary cases against doctors working outside the Clinics before both the GMC and the Home Office's Drugs Tribunals.^{108,109}

The successes of the London Consultants' Group in influencing outside policies was not simply through decisions taken at its meetings, but because of the involvement of many of its members in other important bodies. It was therefore less the meetings themselves, than the perceived sense of being a group with shared interests that could be promulgated in different arenas. While the AIP and AIDA members rarely met outside their own Association meetings, several of the London consultants were colleagues at the Royal College of Psychiatrists, responsible for the postgraduate training of psychiatrists and influential over a range of psychiatric policy. The Royal College of Psychiatrists was also empowered to nominate a member to the GMC, first sending Dr Philip Connell in 1979, and then his replacement Dr Bewley in 1981. Several members were also on the ACMD, and on Department of Health working groups.

Influencing the Media

Access, rather than influence, seems to have been Dr Dally's forte, and her access to the media allowed her to gain publicity for her views. She was friends with and had some support from the editor of the *Lancet*, Ian Munro, whose journal published a strongly written attack on the GMC's

¹⁰⁵ ACMD, (1982), *op. cit.*, pp.51-62.

¹⁰⁶ Medical Working Group on Drug Dependence, (1984) *op. cit.*

¹⁰⁷ UK Health Departments, (1999) *op. cit.*

¹⁰⁸ eg General Medical Council, Professional Conduct Committee, Day One, (9th December 1986), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London: p.1/12.

¹⁰⁹ 'In the Matter of the Misuse of Drugs Act 1971 and in the Matter of Dr John Adrian Garfoot', Day One. [Minutes of proceedings at a Misuse of Drugs Tribunal, Wednesday 22nd June 1994], W B Gurney and Sons, London. Private archive of Dr Garfoot. p.10.

handling of Dr Dally's first disciplinary hearing.¹¹⁰ He later indicated his support for Dr Dally's criticisms of NHS drug treatment stating that 'the inflexibility of the present system is deplorable.'¹¹¹ However, one gets the impression that some of the medical press, rather than take sides, merely enjoyed provoking debate on its pages.

Dr Munro, in a letter to Dr Dally described how his 'misgivings...from the rooted belief that treatment in this area must be separated from any kind of private practice',¹¹² had prompted him to write a leader article which took an opposing line to Dr Dally. He invited her to respond, saying, 'This Lancet contains a leader on drug addiction. The line it takes will hardly meet with your unreserved approval. Why not offer me a letter for publication? Anyway, let's hope we can stir up some debate on this shambles.'¹¹³

A controversial attack on private prescribing by Thomas Bewley and Hamid Ghodse, another NHS Clinic psychiatrist, was published by the *British Medical Journal* the following year under the banner 'For Debate', a suggestion eagerly taken up by a number of its readers (see Chapter 5),¹¹⁴ including a member of AIDA, with Dally's knowledge.^{115,116} Of the wider media, Dr Dally complained 'I talk to many reporters. Only about 1 in 10 writes down anything that seems remotely like what I said.'¹¹⁷

The media had in part acted as a spur to the creation of the AIP. A *News of the World* sting on private psychiatrist Dr Dzikovsky, where a reporter had posed as a patient to test the ease with which he could obtain drugs, encouraged the bad image of private prescribers.^{118,119} In general the AIP received and courted little media attention, although its work was highlighted in Radio Four's 'File on Four' broadcast in 1997 when the Association was attempting to write its own guidelines. The programme gave some recognition to their intentions to self-regulate but overall reflected badly on the behaviour of private prescribers.¹²⁰

¹¹⁰ D. Brahm, 'No right of appeal against GMC finding of serious professional misconduct without suspension or erasure', *Lancet*, i (1983), 600-601.

¹¹¹ I. Munro, Letter to J. Sharp, (20th March 1987), File PP/DAL/B/4/1/3/2, Wellcome Library, London.

¹¹² I. Munro, Letter to A. Dally, (20th January 1982), File PP/DAL/B/1/1/1, Wellcome Library, London.

¹¹³ I. Munro, Letter to A. Dally, (7th January 1982), File PP/DAL/B/1/1/1, Wellcome Library, London.

¹¹⁴ T. Bewley and A. H. Ghodse, 'Unacceptable face of private practice: prescription of controlled drugs to addicts', *British Medical Journal*, 286 (1983), 1876-1877.

¹¹⁵ H.D. Beckett, (1983), *op. cit.*

¹¹⁶ H. D. Beckett, Letter to A. Dally, (17th June 1983), File PP/DAL/B/4/2/1, Wellcome Library, London.

¹¹⁷ A. Dally, Letter to M. Bishop, (5th July 1983), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

¹¹⁸ M. Johnson, (2000) *op. cit.*

¹¹⁹ M. Johnson, (2001) *op. cit.*

¹²⁰ Radio Four, 'File on Four', (1997).

Although individual consultants occasionally appeared in the media, both formal and informal incarnations of the LCG themselves kept low public profiles. For instance, in 1969 a formal Department of Health organised meeting agreed to write to the medical press to express its 'unanimous' condemnation of GPs prescribing methadone.¹²¹ The letter was published in the *British Medical Journal* on 16th May 1970, although Bing Spear later accused the Clinics of misrepresentation, and that excessive quantities of injectable methadone available for sale on the streets originated principally from the Clinics themselves.¹²²

The LCG, in contrast with the two Associations, did not generally publicise their own rules as a group. For instance, it was not until 1991 that the 1968/69 guidelines were published by Philip Connell, and then only as a document of historical interest.¹²³ While the London Consultants did not observe all their own rules or agreements this quieter approach gave them fewer 'hostages to fortune' than AIDA, whose publicly announced rule on the prescribing of *Diconal* was to trip up Dr Dally during her first GMC hearing in 1983.¹²⁴ Furthermore, where rules were published by the London consultants, they still managed to fend off outside intervention or scrutiny and accomplished the feat of setting rules for other doctors to which they themselves did not have to adhere.

Dr Dally took a different approach to the media to Drs Connell and Bewley that reflected their Cultural Theory characteristics and the traditions of policy-making in the drugs field. Dr Dally, an entrepreneurial networker, wished to garner support from any quarter that could help her case. She did not perceive a strong barrier around those inside or outside her group. The London Consultants Group, a group reflecting the hierarchical structure of hospital medicine, by contrast, was restricted to doctors practising in the Clinics. With a strong boundary between insiders and outsiders, members did not usually publicise their views to the general media, preferring to keep the debate on drugs within the medical realm, including medical journals. As discussed in Chapter 5, Dr Connell and Dr Bewley rarely appeared in the general media to rebuff Dr Dally's accusations and criticisms.

¹²¹ DHSS, (January 1970) *op. cit.*

¹²² H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, pp.236-237.

¹²³ P.H. Connell, (1991) *op. cit.*, pp.913-915.

¹²⁴ GMC, Professional Conduct Committee, Day Two [(6 July 1983), Case of Dally, Ann Gwendolen, T A Reed & Co. [transcript], GMC Archive, London, GMC Archive, London. pp.2/11-2/12.

Policy making in the drugs field in the 1960s and the 1970s was carried out behind the scenes in private by accommodation between experts and civil servants.¹²⁵ This held true for the London Consultants Group and it may have been the public nature of Ann Dally's attacks on the Clinics that so embittered the London consultants as much as the content of the attacks themselves. Discussing in public what the London consultants saw as matters for private or medical only discussion broke their code of private policy-making.

Relations Between the Groups

Relations between private prescribers and the London Clinics were generally antagonistic during much of the 1980s, and this was the case between AIDA and the LCG. The minutes of the AIP revealed no references to the London Consultants as a group, and their concerns were directed more at self-regulation and self-defence. It has not been possible to trace whether the LCG was aware of the AIP during its brief existence, or what its reaction might have been to its activities. Although there was no chronological overlap between AIDA and the AIP, some members and even a draft of AIDA's guidelines were shared between the two.

AIDA supposedly wanted closer cooperation between the doctors outside and inside the Clinics and in response to John Strang's 'Personal View' article in the *British Medical Journal*,¹²⁶ Dr Dally wrote a letter to its editor for publication, explaining that, 'Clinics can also provide what independent doctors usually cannot provide, for example, group decisions in patient treatment and group psychotherapy'. She concluded in conciliatory tone, 'It is vital that the Clinic and independent doctor co-operate with each other. Failure to do so along the lines suggested by Dr Strang can only harm the patients.'¹²⁷

In a letter written to the *Lancet* for publication, as AIDA's 'Founder and Organiser' she suggested a number of measures to help the drug treatment situation, first of which was 'Concerted efforts of doctors and others who work in the field to co-operate and not to descend to slanging matches about how awful, stupid, indifferent, greedy or wicked the other groups are,' a standard she was not herself able to maintain.¹²⁸ She wrote to the newspapers criticising the Clinics' approaches, and

¹²⁵ G. V. Stimson and R. Iart, 'The Relationship Between the State and Local Practice in the Development of National Policy on Drugs between 1920 and 1990', in J. Strang and M. Gossop (eds), *Heroin Addiction And Drug Policy: The British System* (Oxford, New York, Tokyo, Oxford University Press, 1994), pp.331-341, p.336.

¹²⁶ J. Strang, 'Personal view', *British Medical Journal*, 284 (1982), 972.

¹²⁷ A. Dally, 'Opiate addiction and the independent doctor', Letter to the Editor, *British Medical Journal*, (2nd April 1982) File PP/DAL/B/4/2/1, Wellcome Library, London.

¹²⁸ A. Dally, Letter to the Editor, *Lancet*, for publication, (12th January 1982), File PP/DAL/B/4/1/1/1, Wellcome Library, London.

individual doctors such as Connell.¹²⁹ The constant criticism aimed at the Clinics by AIDA suggested that a spirit of cooperation was not being fostered. AIDA's draft guidelines themselves opened with a number of volleys aimed at the Clinics, and several of the letters written for publication contained attacks too.^{130,131}

In 1982 Dr Dally sought a meeting with the Clinic doctors, but apparently with no success. Writing to Ted Hillier in the DHSS's drugs branch, on the suggestion of Bing Spear, to establish communication with the 'Clinic doctors', she complained, 'We have made a number of overtures to them but have met with no success. We would very much like representatives of this Association to meet with appropriate people to discuss matters of common interest.'¹³² Martin Mitcheson did not recall these 'overtures', but took the view that they would have been resisted had they been received.¹³³

Regulating Other Doctors

Both AIDA and the AIP's regulatory gazes were directed mainly at their own members, but the LCG set the rules by which other doctors were regulated. Consultants with concerns about the practices of other doctors could take a number of paths. They might contact the Regional Health Authority whose advisors could visit a doctor, write to the individual doctor themselves, or mention their concerns to a Drugs Branch Inspector.¹³⁴ This third approach could arise through an LCG meeting at the Home Office, or through a range of other contacts doctors had with the Home Office. Martin Mitcheson, for instance, used to visit Bing Spear in the course of his research at the Addiction Research Unit of the Institute of Psychiatry, and doctors phoning the Drugs Branch to notify the Addicts Index could also discuss regulatory action.

Before the 1984 *Guidelines* had been published, over which the London Consultants had been decisive, the Home Office Drugs Branch relied in part on advice and publications from the London consultants as to the appropriate practice standards they should enforce.¹³⁵ Furthermore, there were no cases of Home Office tribunals being used against the London Clinic doctors for inappropriate prescribing. This was not because they achieved total uniformity of practice, but

¹²⁹ eg. A. Dally, Letter to *The Times*, (27th January 1981), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

¹³⁰ AIDA, (February 1982) *op. cit.*, p.1.

¹³¹ eg. A. Dally, (8th April 1983) *op. cit.*

¹³² A. Dally, Letter to T. Hillier, (20th September 1982), File PP/DAL/B/4/1/1/1 (File 1 of 2), Wellcome Library, London.

¹³³ M. Mitcheson, (2003) *op. cit.*

¹³⁴ *Ibid.*

¹³⁵ Home Office Inspector, Interview by Sarah Mars, (2002).

because they were left to self-regulate. According to an inspector who worked in the Drugs Branch since the late 1980s,

They all prescribed somewhat differently...there is a core of activities that are common to them all but then there are others; Strang would do injectables, [St] George's don't do injectables and things like that...there are slight differences. I think they tend to see that they should be held up as the model prescribers...Seeing as John Strang chairs most of these committees anyway, in a sense he should be doing what they said and other consultants accordingly.¹³⁶

The process of regulation was described as follows:

The London consultants have a quarterly meeting is held here [Home Office], which I've attended since 1987. And part of that is sharing of information about drug misuse, prescribing, and sorts of things like that. So if I'd have, which I didn't have, if I'd said I'd got concerns about a particular doctor who was a consultant, I'd have probably spoken to Hamid Ghodse initially [convener of London Consultants Group]. And he would have, or John Strang, or someone like that, and perhaps persuaded them or perhaps asked them to perhaps have a quiet word in their ear about what's going on. Certainly they always felt that they should be supportive to each other, and that if things, there was one of their doctors going out of line they should try and put them on the straight and narrow.¹³⁷

The idea of doctors being 'supportive to each other' shows the shared sense of a group interest and identity that was weak in AIDA and the AIP. The inspector answered the question 'What if one of the Drugs Branch had concerns about a consultant's prescribing?' as follows:

Home Office Inspector: Well, if they did, I never heard about it. There was this one occasion when I can think of where the other consultants had concerns about someone prescribing and that needed to look at the boundaries of their...'

SM: So the consultants were self-regulating in that sense, they kept an eye on each other.'

Home Office Inspector: Yes.¹³⁸

So here was the LCG informally reporting non-Clinic doctors to the Home Office Drugs Inspectorate for regulatory investigation, apparently immune from challenge by the Inspectorate, while concerns about their own members were dealt with among themselves. The single exception to this reliance upon informal, internal regulation was the case of Dr Kanagaratnam Sathananthan, who was not only an advocate of continued heroin prescribing on a maintenance basis after the Clinics had changed their practice, but the only doctor licensed to prescribe heroin privately. The GMC and the Home Office Inspectorate became interested in his private and NHS prescribing

¹³⁶ *Ibid.*

¹³⁷ *Ibid.*

¹³⁸ *Ibid.*

respectively, but he retained his freedom to practice and his Home Office heroin licence. If it was Dr Connell, as has been suggested,¹³⁹ who was behind these inquiries, it seems likely that Dr Sathananthan was treated differently by his colleagues because he was a private prescriber. Whether his outsider status was also due to being originally from Sri Lanka is unclear.

Relations with the State

The role of the state in each organisation was different and acted not as a monolithic entity with a single interest, but part of a complex policy network itself reflecting and pursuing a number of different interests. AIDA's encouragement from the Chief Inspector of the Drugs Branch, represented Spear's support for doctors to be free to give injectable and maintenance prescriptions and his concerns about the monopoly of treatment provided by the Clinics. Spear contributed a factual section of AIDA's draft guidelines describing the legal position of doctors prescribing for addicts and the notification procedure for the Addicts Index,¹⁴⁰ but his views on treatment policy were very discreetly held while employed. During his service he promoted his own preferences through quietly supporting others, such as AIDA, behind the scenes, but after retirement he began to campaign more openly. In 1987 he wrote to one of Dr Dally's supporters, praising Dr John Marks, a dissenting NIS psychiatrist who was a vocal proponent of heroin prescription at his Liverpool DIDU:

I am not too despondent as there are signs that a rethink is around the corner and a more flexible approach [to prescribing] may be adopted. I think we should all do what we can to support those doctors, like Dr Marks in Liverpool, who are proposing this and I suggest, when the election is over, you should put your point to your local MP.¹⁴¹

In the memoirs published after his death, Bing Spear lamented,

With the benefit of hindsight there is no doubt that the treatment centre era was an unmitigated disaster, not because the basic idea was wrong but because of the way in which that idea was developed and implemented. What happened was that the moral high ground was seized by a small group within the medical establishment, and by psychiatrists in particular, who, over the years succeeded in imposing their own ethical and judgemental values on treatment policy. As a consequence there is now very little prescribing of heroin, or any injectable drug, to addicts.¹⁴²

Whilst quietly encouraging AIDA, Mr Spear was also wary of becoming too closely involved, writing, 'I remember, after attending an AIDA meeting at which a very doubtful prescriber was

¹³⁹ C. Fazey, Interview by Sarah Mars, (2002).

¹⁴⁰ H. B. Spear, Letter to A. Dally, (1st February 1982), File PP/DAL/B/4/2/1, Wellcome Library, London.

¹⁴¹ H. B. Spear, Letter to Mr Emery, (17th May 1987), File PP/DAL/B/4/1/3/2, Wellcome Library, London.

¹⁴² H. B. Spear (and ed. J. Mott), (2002) *op. cit.*, p.310.

present, noting that we should be careful in our dealings with the Association because it was by no means unlikely that some of those who applied for membership might in due course be regarded as candidates for tribunal action.¹⁴³

Dorothy Black, while senior medical officer at the DHSS, attended the first AIDA meeting and commenting upon its draft guidelines. She too was careful to distance herself, writing to Dr Dally to correct the minuted description of herself as an 'observer', a status apparently restricted to civil servants attending major external meetings.¹⁴⁴

Spear's support for AIDA did not represent ministers' direction of policy. Indeed the lack of a strong interest from politicians in the finer points of prescribing left civil servants to form their own policies within their wider brief. In this way, Spear worked to his own agenda, which included support for prescribing heroin and alternatives to the Clinics. He knew almost everyone in the drug treatment field and formed alliances to push through his policies. For instance, when a complaint was made against Dr Kanagaratnam Sathananthan, he sought out researcher Cindy Fazey to assess his private clinic. As a sociologist, Fazey was an unusual choice, but known to be sympathetic to Dr Sathananthan's style of prescribing. According to Professor Fazey, it was Philip Connell who was behind the attacks on Dr Sathananthan, and with his hatred of Connell, Spear interpreted this as a vendetta, motivated by personal dislike.¹⁴⁵ Fazey's report exonerated Sathananthan's prescribing. She also appeared as a witness for the defence at GMC hearings of both Dr Sathananthan and Dr Dally. Along with John Marks she formed part of an anti-London-Clinic, pro-maintenance faction. Professor John Strang conducted an investigation into Dr Sathananthan's NHS clinic but also found no unprofessional conduct.^{146,147}

The AIP had little contact with central government but had originated from a meeting with the local government and local statutory agencies. The Director of Public Health for Kensington and Chelsea and Westminster Health Authority, Dr Sally Hargreaves,¹⁴⁸ continued to liaise with members of the AIP about progress on self-regulation. This culminated in a joint project between the NHS and the private sector, where KCWHA funded the Hanway Clinic to provide a drugs clinic for homeless patients in Soho, a sign of

¹⁴³ *Ibid.* p.287.

¹⁴⁴ D. Black, Letter to A. Dally, (19th March 1982), File PP/DAL/B/4/1/1/5, Wellcome Library, London.

¹⁴⁵ C. Fazey, (2002) *op. cit.*

¹⁴⁶ J. Strang, Personal communication, (2000).

¹⁴⁷ K. Sathananthan, Interview by Sarah Mars, (2001).

¹⁴⁸ 'Private Prescribing and Community Safety', (29th August 1996), *op. cit.*

the blurred boundaries between public and private more common in the 1990s.¹⁴⁹ However, there was little sense that government wished to consult these doctors on policy changes. Although Anthony Thorley, Senior Medical Officer at the Department of Health, stated that there would be a consultation on the draft clinical guidelines that were being revised, and that their input would be welcomed, the absence of any private prescribers on the committee itself reinforced the impression that this was mainly cosmetic.¹⁵⁰ In the event, there was no consultation on the draft guidelines, which were published in their finalised form in 1999. As the LCG's origins were tied to central government, its relationship has already been discussed above.

Strengths and Weaknesses

Unifying factors

Both AIDA and the AIP had diverse memberships, but shared a belief in the value of maintenance prescribing and treatment outside the NHS Clinics. The working arrangements of the members were probably less important than their beliefs about drug control and supply. For instance, Dale Beckett had been an NHS Clinic consultant psychiatrist before going private, but he believed in far more liberal access to drugs and free prescribing of heroin. Dr Diana Samways resigned from AIDA, protesting about its emphasis on maintenance prescribing, and the charging of fees, writing, 'I feel very concerned about the prescribing of drugs (and for money) to addicts, it seems to me that AIDA is a forum for the justification of this. I also felt that any other views on the treatment were heresy, and not for discussion at AIDA.'¹⁵¹ As well as the treatment approaches that members of the AIP favoured, they were also drawn together by a sense of threat from the media and regulatory bodies.

In addition to the views that developed on prescribing outside the Clinics, many members of the LCG, such as Drs Willis, Bewley, Mitcheson, Ghodse and Connell, specifically opposed private prescribing where a doctor was paid directly by patient fee.^{152,153,154} Where private prescribers were thought to be a problem, they were discussed and it was then for the Home Office to decide on whether to take action.¹⁵⁵ However, Martin Mitcheson recalled a deputation of Drs Connell and Bewley to be sent on behalf of the group to visit Ann Dally and express their concern. 'There was

¹⁴⁹ S. L. Hayward, (2003) *op. cit.*

¹⁵⁰ 'Private Prescribing and Community Safety', (29th August 1996), *op. cit.*

¹⁵¹ D. Samways, (9th August 1982) *op. cit.*

¹⁵² J. Willis, (2003) *op. cit.*

¹⁵³ M. Mitcheson, (2003) *op. cit.*

¹⁵⁴ T. Bewley and A. H. Ghodse, (1983) *op. cit.*, pp.1876-1877.

¹⁵⁵ T. H. Bewley, (2001) *op. cit.*

some uncertainty over this event however, as Dr Dally made no mention of this in her autobiography. What is more certain is that Dr Bewley reported Dr Dally to the GMC in 1984, although it decided to take no action.¹⁵⁶

The London Consultants Group seems to have had the strongest sense of locality, which it drew around itself as a boundary to outsiders. Within London the members defined catchment areas for their patients, and there was a strong sense that the London scene was unique in scale and patterns of drug use. With this came a rather unreceptive attitude towards their peers working in the provinces, one of whom recalled, 'I can remember as a clinician coming down from Sheffield, in the late, probably about '79 and talking about *Diconal* and I can remember the London consultants looking at me as if I had no idea what I was talking about, because they'd never heard of the drug, because it wasn't being used in London whereas it was a major problem in the north of England'.¹⁵⁷ Equally, a member of the LCG explained, 'There was also the feeling that we had a lot happening between ourselves with our patients and most of the activity around treatment was around the centre of London anyway and quite frankly, I think some of us got rather fed up hearing someone like [consultant from outside London] telling us what type of tablets were popular with his ten addicts... We had a lot of things to talk about amongst ourselves.'¹⁵⁸

The AIP inevitably drew its membership from in and around London, as large scale private prescribing was virtually unknown outside the south east of England, and AIDA, which encouraged national membership from GPs had a much wider spread. This may have made it more difficult for its members to meet, as they had further to travel.

An ability to trust each other gives the members of a group an advantage in working together as information can be shared openly. As might be expected from a group with a greater sense of shared purpose, a strong boundary drawn against outsiders and less direct competition between members, there was greater trust within the London Consultants Group than with the AIP, whose members were in competition. For instance, at the AIP's meeting on 13th March 1997, those present discussed the possibility of forming a consortium to buy urine tests and detoxification units,¹⁵⁹ but this never came to fruition, probably because buying as a consortium would have revealed sensitive information such as which doctors were not using urine tests. A year earlier forms had been distributed in order to collect information from doctor members on their patient

¹⁵⁶ A. Dally, (1990) *op. cit.*, p.141.

¹⁵⁷ Consultant Psychiatrist, Interview by Sarah Mars, (2001).

¹⁵⁸ J. Mack, (2003) *op. cit.*

¹⁵⁹ AIP, (13th March 1997), *op. cit.*

caseloads, fees, and other details. There was reportedly some reluctance to complete these partly for commercial reasons, and also because one could work out a doctor's gross income by multiplying fees by numbers of patients.¹⁶⁰ In contrast John Mack described an implicit confidentiality of the meetings of the LCG; an understanding that you could speak freely in front of your colleagues and civil servants.¹⁶¹ The fact that an individual member did not feel free to share papers until the group had been formally consulted, reinforced the sense of trust and basis for confidentiality. Unfortunately the data available on AIDA did not give a clear picture of the degree of trust between members.

Divisive Factors

The antagonistic position AIDA began to take towards the Clinics may have reduced AIDA's strength and appeal both within and outside its membership. While they were serving together on the DHSS's Medical Working Group, Ann Dally invited GP Arthur Banks to join her Association. Dr Banks was well respected in the drugs field and had considerable experience in treating drug users, receiving praise for the booklet he co-wrote on the subject.^{162,163} Although in agreement with Dr Dally on many issues, both opposing the proposed extension of licensing for prescribing doctors in 1984 (see Chapter 4), and keen to attend a meeting of AIDA, he declined to join, explaining, 'There seem to be very widely divergent views in the drug treatment world, with clinics and independents and social-model workers often strongly condemning each others' policies. I am torn between the various views, or perhaps trying to remain neutral; I share many of the criticisms of the clinics but am not happy about being "independent" either.'¹⁶⁴ Having a member such as Dr Banks would not only have helped in terms of achieving external influence, but he could also have helped train and advise AIDA's less experienced members.

Dr Diana Samways remarked in her letter of resignation from AIDA, 'I am sorry to hear the negative attitude AIDA members have to the Treatment Centres, and having worked in the St Bernard's Unit, I am aware of the problems we all face.'¹⁶⁵ Dr Dorothy Black, Senior Medical Officer at the DHSS, chided Dr Dally for her oppositional stance in AIDA's draft guidelines.¹⁶⁶

¹⁶⁰ M. Johnson, (2001) *op. cit.*

¹⁶¹ J. Mack, (2003) *op. cit.*

¹⁶² A. Banks and T. A. N. Waller, *Drug Addiction and Polydrug Use: The Role of the General Practitioner* (London: ISDD, 1983).

¹⁶³ Senior Civil Servant, DHSS, (2001) *op. cit.*

¹⁶⁴ A. Banks, Letter to A. Dally, (15th March 1984), File PP/DAL/B/5/1/2, Wellcome Library, London.

¹⁶⁵ D. Samways, (9th August 1982) *op. cit.*

¹⁶⁶ D. Black, (19th March 1982) *op. cit.*

The LCG suffered disagreements within its ranks too, with a range of opinion on, for instance, the prescribing of injectable drugs, but the proponents of a particular point of view, such as Drs Connell and Bewley regarding the opposition to heroin and injectable methadone, were able to get their views adopted by most of the group and achieve a change in practice across the Clinics (see Chapter 4).

A problem that seems to have occurred with both AIDA and the AIP was a feeling among some members that disreputable doctors were using the associations as a 'cloak of respectability' and had no intentions of changing their practice. A letter from an NHS GP and AIDA member early in the organisation's life expressed concern that 'AIDA might act as a front for potentially unscrupulous doctors wishing to benefit from prescribing privately for drug addicts'.¹⁶⁷ Dr Dally herself was concerned about this possibility from the outset. Writing to GP member and friend Susan Openshaw, she asked her for advice on 'what we should do with people who quite definitely are using it as a blanket of respectability and who are not attempting to keep up high standards of practice'.¹⁶⁸

Matthew Johnson felt that this syndrome afflicted the AIP and undermined the other doctors' willingness to lend support. The expulsion of two doctors might have helped this, but then, given that the organisation had no other sanctions to apply, the expelled doctors could continue to practice outside the association, which then had no influence on them at all.¹⁶⁹ One was eventually struck off the medical register by the GMC.

The private prescribers of the AIP seemed to divide into three groups: those attracting adverse publicity who wanted to improve their respectability through association; those with no regulatory difficulties, who wanted to 'keep their heads down' and perceived that they had nothing to gain from associating with less respectable doctors, and those who wanted to achieve change, and improve the standing of private prescribing through group action.

Doctors with no trouble from the regulatory authorities, such as Dale Beckett and Jeremy Bullock, did not attend the AIP, as they perceived no need to club together for protection. Being individualistic operators they did not take the view that to 'attack one of us is to attack all of us'.

¹⁶⁷ B. Jarman, Letter to A. Dally, (7th April 1982), File PP/DAL/B/4/2/1, Wellcome Library, London.

¹⁶⁸ A. Dally, Letter to S. Openshaw, (11th February 1982), File PP/DAL/B/1/1/1, Wellcome Library, London.

¹⁶⁹ M. Johnson, (2000) *op. cit.*

This inevitably reduced the number of 'respectable' members.¹⁷⁰ Furthermore, once the first two groups were not attending – those not interested, and those using it for their own purposes – the remaining doctors were few and it was a case of 'preaching to the converted'.¹⁷¹

Competition between doctors for patients was also divisive to the group. At one AIP meeting, 'It was noted that clients can and do change doctors if they can access higher levels of prescribing even though they have managed well on lower doses. This was an issue of concern'.¹⁷²

Most of the London Consultants already had respectability within government and among the public from their positions within the NHS and 'establishment' organisations, although they complained of low status within psychiatry.¹⁷³ Promotion within the NHS relied upon being acceptable to one's peers and superiors, criteria missing from the private doctors, who could work in their own businesses regardless of selection procedures. With the exception of Dr Sathanathan in Croydon, members who were perhaps more unorthodox, and continued to prescribe heroin, such as James Willis, either left of their own accord or were subjected to other external pressures;¹⁷⁴ Dr Dale Beckett's NHS clinic was closed down reportedly because of the hospital's dislike of drug user patients.^{175,176}

The position and role of the LCG during the 1990s is less clear due to the inaccessibility of any documents from those meetings. Unlike Philip Connell in his day, the most senior consultant at the end of the century, Professor John Strang, rarely attended the meetings, and it seemed that a greater diversity of approaches to prescribing was tolerated inside the London Clinics, but determining the reasons for this would require greater access to source materials than is currently possible.

Conclusion

Comparing the AIP with AIDA points up the changed policy environment facing private prescribers in the 1990s. The AIP's origins in local concerns reflected the diminishing significance of the private prescribing issue on the national policy agenda, and the increase in local policy responses to drug issues. The AIP still attracted some interest from the

¹⁷⁰ M. Johnson, (2001) *op. cit.*

¹⁷¹ *Ibid.*

¹⁷² AIP, (10th December 1996) *op. cit.*

¹⁷³ T. H. Bewley, (2001) *op. cit.*

¹⁷⁴ J. Willis, (2003) *op. cit.*

¹⁷⁵ H. D. Beckett, (2001) *op. cit.*

¹⁷⁶ H. B. Spear (and J. Mott ed.), (2002) *op. cit.*, p.192.

Department of Health and Home Office, and psychiatrists and central government civil servants were still using opportunities for national policy making to regulate private prescribers in the 1990s, as in the attempted extension of licensing in 1999/2000. Yet the origins of and response to the AIP showed the growth in significance of local policy-making in the drugs field and the marginalisation of private prescribers.

Overall, the weaknesses of the AIP and AIDA were that they had no sanctions that could be applied to non-conforming members, other than expulsion, and so could not enforce their policies, but this could equally be said of the LCG, so what made the difference? The London Clinics, created by the Ministry of Health to address the problems identified in the Second Brain Report,¹⁷⁷ already had a stronger relationship with the state than the private doctors, and its leaders embedded themselves further within establishment bodies, such as the GMC and Royal College of Psychiatrists, which they could then marshal against perceived threats outside.

Strong leadership from the forceful Dr Dally could not bring consensus within AIDA, which failed to produce consensus guidelines, 'agreeing to disagree'. By contrast the LCG was willing in the 1970s and '80s to make the sacrifices in individual autonomy required by its leadership to increase its corporate autonomy. This can be explained through the wider institutional power bases of the dominant Drs Connell and Bewley beyond their personal qualities, the hierarchical nature of hospital medicine, and the multi-stranded relationships within the LCG.

Max Gluckman, in his analysis of feuding societies in Africa and their settlement mechanisms, identified different allegiances across a number of settings as the root of social cohesion: a feud with someone in one arena threatened that relationship across several settings and therefore more was at stake and there was a greater interest in settling the dispute.¹⁷⁸ The London consultants encountered each other in the Advisory Council on the Misuse of Drugs, at the Royal College of Psychiatrists, at the Society for the Study of Addiction, and on working parties. AIP and AIDA members rarely encountered each other in different occupational settings, and felt they had less to lose by staying true to their own preferences. History suggests they were mistaken.

¹⁷⁷ Interdepartmental Committee on Drug Addiction. *The Second Report of the Interdepartmental Committee* (London: HMSO, 1965).

¹⁷⁸ M. Gluckman, *Custom and Conflict in Africa* (Oxford: Basil Blackwell, first published 1956, this edition 1982).

Chapter 9: Summary and Conclusions

Introduction

The 'public' and 'private' terms that began this journey have evolved in meaning as their limitations have become clear, so before reflecting on the main conclusions of the research, their use needs some clarification. When presented in the form of published literature, the debate between doctors working privately and those working for the NHS in the drugs field has been denoted as a clash of sectors – 'public' against 'private' – particularly when seen from the viewpoint of consultant psychiatrists working exclusively in the NHS. Official documents also distinguished private prescribers from NHS doctors as individuals. However, the interviews carried out revealed that many of the doctors involved in the private sector also worked in the NHS and some have had lengthy careers in the NHS before their private practice. Of the private doctors prescribing to drug users and paid by fee interviewed between 2000 and 2003 more than half (8/14) had been or were still working for the NHS (see Appendix A).

Furthermore, the private 'sector' was much wider than those doctors involved in the 'public-private' debate, with significant provision of drug free care by private psychiatric hospitals. Since private hospital care rarely involved the prescribing of substitute pharmaceuticals such as methadone it could not be held responsible for supplying the illicit market in prescribed drugs or for overdose deaths and it has remained uncontroversial and outside the debate.

This research therefore has used the term 'private prescriber' to denote the doctors whose treatment involved prescribing substitute drugs and who accepted fees for their services and 'drug doctor' for someone significantly involved in treating drug problems with or without prescribed drugs; the word 'sector' has been avoided as the overlap between 'public' and 'private' was greater than at first supposed. Blurring these boundaries further, it transpired that in the 1990s private doctors also received patient referrals from the NHS, and occasionally might be paid by social services or from other public funds to carry out their work.

Private prescribing has been virtually unknown outside the south east of England being almost entirely concentrated in London. While much private health care has traditionally been focused in the metropolis, it was surprising to find such a stark contrast between the south east and the rest of the country in this field. A market explanation did not seem convincing, as large populations of

drug users were present in cities outside London from the 1980s, and grew steadily. Furthermore, private practice could be undertaken by NHS GPs on a small scale if demand was low. Despite extensive enquiries, no conclusive answer to this puzzle has been found, but it might have been explained by differences in policing by the Home Office Inspectorate and the police. Both had regional structures, and some interviewees have suggested that tolerance of private prescribing was greater among Home Office inspectors in the south east than outside. Yet although private prescribing was a metropolitan phenomenon, it was usually discussed as a national issue, with national policy implications.

The research has been organised around twin axes, looking at the debate both chronologically, through historical periodisation, and thematically, through cross-cutting issues that developed across time. The results have shown three major phases in relations between public and private:

Chronology

1968-mid 1970s: Experimentation and co-existence

Major regulatory changes in the late 1960s had moved prescribing to drug users away from primary NHS care and into the Clinics. Private doctors, both specialist and generalist, continued to prescribe, but the numbers of addicts were very small and the Clinics seemed able to meet demand.¹ Characterised by fluidity in treatment regimes and some degree of co-existence between the public Clinics and private prescribers, this was a time of experiment and uncertainty.²

Before treatment allegiances solidified in the mid-1970s, the Clinics tried out many types of prescribing, including amphetamines and cocaine, which were later abandoned. Heroin and methadone were prescribed in injectable form on a long term maintenance basis. Prior to a clinical trial of oral methadone and injectable heroin carried out at University College Hospital Drug Dependency Unit, when psychiatric preferences for oral methadone started to coalesce, prescribing could involve cocktails of stimulants and depressants, bargained over by doctors and patients.

One of the concerns of the London consultant psychiatrists was the range of prescribing styles both among their own members, and outside. The London Consultants Group, initially a policy forum and information exchange with the Ministry of Health, developed an informal regulatory role.

¹ D. Hawks, 'The dimensions of drug dependence in the United Kingdom' in G. Edwards, M. A. H. Russell, D. Hawks *et al.* (eds.), *Drugs and Drug Dependence* (Farnborough, Hants., England: Saxon House and Lexington, Mass., USA: Lexington Books, 1976) pp.5-29.

² T. Bewley, Interview by Sarah Mars, (2001).

At this stage, when Clinics prescribed generously to addicts with few of the restrictions that were later introduced, their approach was closer to the private prescribers. Patients had less to gain from 'going private' and there was less conflict between the different doctors. The drugs policy community was small, consisting of civil servants, politicians and other concerned individuals: with an interest in drug users, and NHS psychiatrists, concentrated around the Home Office rather than the Department of Health, and did not attract much ministerial interest.

Late 1970s to 1982: Hardening lines of allegiance

This phase saw the development of strong allegiances to particular treatment approaches, a widening gap between NHS and private prescribing styles and a shift of drug users seeking help among private and NHS doctors outside the Clinics. The Clinics' prescribing changes were corralled and reinforced through the hierarchical London Consultants Group, while individualistic, autonomous doctors outside tried unsuccessfully to unify through their own new association. Medicine's dominance of the drugs policy community softened, as the growing voluntary sector, which tended to represent a more social and less medical model of drug misuse, gained greater recognition. At the end of this phase drugs began to assume a higher political profile, attracting renewed ministerial interest.

Although licences to prescribe heroin had been almost entirely restricted to psychiatrists running the Clinics, their services voluntarily moved away from this practice at the end of the 1970s, replacing maintenance prescribing with short term oral methadone detoxification. These changes were achieved across the Clinics through a process of face-to-face peer pressure exercised through the London Consultants Group, and attempts to extend this process outside the Clinic system involved moves to increase the regulation of private doctors and NHS GPs.

Despite an original aim of undercutting the black market through 'competitive prescribing', the Clinics had abandoned this model by the late 1970s. The near monopoly of treatment they held, the politically weak and stigmatised status of their patients, and the absence of market forces had allowed the Clinics to become unresponsive to the preferences of their patients, while the private doctors, practising on a more consumerist model, were able to supply unmet demand. Although the voluntary sector had been providing drug services for many years, these were typically not medical and did not prescribe.

With the change in the main source of illicit opiates from doctors' prescriptions to trafficked drugs at the end of the 1970s, doctors found that instead of being the chief guardians of the drug supply, they now faced major competition from a fully fledged black market in imported heroin, and a growing pool of demand across the country. The Clinics found they had insufficient treatment places and drug users were increasingly looking elsewhere for treatment. Over the 1970s the proportion of patients seeing GPs practising privately and on the NHS grew in both absolute terms and as a proportion of all those seen by doctors. NHS GPs had had little involvement in the treatment of addiction since the establishment of the Clinics, and minimal training. Private doctors continued to offer long term maintenance prescribing of methadone, both injectable and oral. Bing Spear dated disquiet over these perceived incursions into the Clinics' territory to 1979, when they were discussed at a London Consultants Group meeting.³

Attacks on private prescribing started to appear in the medical press from 1980,⁴ and the issues were remarked upon by the ACMD's *Treatment and Rehabilitation* report two years later. This research has proven that particular Clinic doctors already opposed to private prescribing influenced the drafting of *Treatment & Rehabilitation* to propose extensive curbs on prescribing by doctors outside.⁵ They recommended a raft of corrective measures that included the preparation of 'good practice' prescribing guidelines by an all-medical working group.

Among psychiatrists across the London Clinics, there were a range of views on the wisdom of maintenance prescribing. However, those in the most powerful positions favoured abstinence-oriented treatment over longer term prescribing, methadone over heroin and oral over injectable formulations; Dr Philip Connell and Dr Thomas Bewley seemed successful in convincing the majority of their peers to follow their views. Both held influential clinical and medico-political positions, including on the GMC and later on the first guidelines working group.

The London Clinics' unified approach to prescribing was facilitated by their consultants' regular meetings where they shared information and standardised practice from 1968, described by one member as 'typically English, discreet peer group pressure tending to moderate the prescribing of heroin' in order to prevent drugs being traded illegally.⁶

³ H. B. Spear (and ed. J. Mott), *Heroin Addiction Care and Control: The 'British System' 1916-1984* (London: Drugscope, 2002) pp.275-276.

⁴ T.H. Bewley, 'Prescribing Psychoactive Drugs to Addicts', *British Medical Journal*, 281 (1980), 497-498.

⁵ ACMD, *Treatment and Rehabilitation*, DHSS (London: HMSO, 1982).

⁶ M. Mitcheson, 'Drug Clinics in the 1970s' in J. Strang and M. Gossop (eds.), *Heroin Addiction and Drug Policy: The British System* (Oxford, New York, Tokyo: Oxford University Press, 1994), pp.178-191, pp.178-180.

With the encouragement of a senior civil servant sympathetic towards private prescribers and maintenance prescribing, drug doctors outside the Clinics, both NHS and private, set up their own 'Association of Independent Doctors in Addiction' (AIDA) in 1981, and attempted, ahead of the field, to produce their own good practice guidelines and other policies to raise standards and self-regulate. In contrast to the hierarchical psychiatrists, whose group dynamics allowed them to sacrifice individual for the sake of corporate autonomy,⁷ the individualistic doctors of AIDA were unable to achieve unity and gained little influence either internally or externally.

Perhaps one of the most remarkable aspects of the public-private debate and the accusations of over-prescribing levelled at private doctors, is how they intensified during a period when the trade in prescribed pharmaceuticals had become so overshadowed by the dramatically growing market in trafficked drugs. This reinforced the sense that the debate was more about the control of doctors than the actual fate of the drugs and the drug users themselves.

1983-1999: Guidelines and regulatory battles

(i) 1983-87: 'Harm reduction' outside the policy community

These years saw the first clinical guidelines on the treatment of drug users emerge from a group of policy actors strongly committed to abstinence based treatment. Although included for the sake of appearance in the policy process, private prescribers advocating a more pragmatic approach, later termed 'harm reduction', remained on the outside of policy-making.⁸ Under the Conservative Government, drugs became a highly political issue, with substantial resources allocated to services, high profile media campaigns and the first comprehensive government strategy document for drugs policy in 1985. The details of prescribing, however, were left to doctors. The battle between private prescribers and NHS psychiatrists heated up and Ann Dally, the outspoken voice of AIDA, was the subject of two GMC disciplinary hearings, quitting her practice in 1987. Although the voluntary sector had taken some of the medical profession's seats in the drugs policy community, doctors successfully defended prescribing as solely their domain.

The control of private doctors was a major, and possibly the primary motivation for the first good practice guidelines that involved a process designed to achieve the appearance of consensus across

⁷ See also R. Klein, *The New Politics of the National Health Service*, (London and New York: Longman, first published 1983, third edition 1995) pp.51-62.

⁸ S. Mars, 'Peer Pressure and Imposed Consensus: The Making of the 1984 "Guidelines of Good Clinical Practice in the Treatment of Drug Misuse"' in V. Berridge (ed.), *Making Health Policy: Networks in Research and Policy After 1945* (Amsterdam: Rodopi, 2005) pp.149-182.

a divided profession. For the first time, the claims made in Dr Ann Dally's autobiography about changes in committee procedures that facilitated this apparent consensus have been proven.^{9,10}

After the official reversal of policy to reinvolve GPs in treating drug users, the perceived urgency of attracting drug users into treatment was heightened in the years when the issue of HIV/AIDS and its transmissibility through sharing injecting equipment began to influence drug treatment policies.¹¹

While the London consultants continued to be a strong force through this phase, effectively exercising regulatory influence over private doctors such as Ann Dally, her own organisation struggled to attract support or garner influence. In AIDA there was a merging of Dr Dally's own personal difficulties with the GMC with the wider concerns of her colleagues, partly as a result of her view that the personal was political in this case,¹² and partly because of her dominant, charismatic role in what became a relatively unstructured organisation. By the end of its life in 1987/88, it aimed less at raising standards among doctors outside the Clinics and more at supporting Dr Dally in her time of trial. By 1987 AIDA was unstructured with no committee, and the following year folded 'for lack of interest'.¹³ Strong leadership was not enough to bind together a group of independent individualists, working outside the hierarchical hospital system, who were unwilling to compromise their autonomy for longer-term gains.

(ii) 1988-99: 'Harm reduction' inside the policy community

With HIV/AIDS high on the policy agenda, this period dated from the official endorsement of a policy of 'harm reduction' and coincided with Ann Dally leaving the scene. Regulatory battles continued, but the issue of private prescribing became less prominent as 'harm reduction' was absorbed into the mainstream drugs agenda and NHS services expanded, dwarfing the private prescribers' contribution that was still concentrated in the South East. The policy community diversified further with more representatives from the criminal justice system at central and local level, reflecting a strong legislative emphasis on penal responses to drug issues.¹⁴ By the late '90s, drug doctors had even conceded their last bastion of medical exclusivity, prescribing, to at least an

⁹ A. Dally, *A Doctor's Story* (London: Macmillan, 1990) pp.127-132.

¹⁰ S. Mars, (2005) *op. cit.*, p.169.

¹¹ V. Berridge, *AIDS in the UK. The Making of Policy, 1981-1994* (Oxford: Oxford University Press, 1996) pp.223-224.

¹² See Ann Dally's description of the cases in *A Doctor's Story* (1990) *op. cit.*, pp.99-218.

¹³ C. Brewer, Letter to Ann Dally, (27th June 1988), File PP/DAL/B/4/1/1/1 (File 2 of 2), Wellcome Library, London.

¹⁴ V. Berridge, 'AIDS and British drug policy: continuity or change?' in V. Berridge and P. Strong (eds.), *AIDS and Contemporary History* (Cambridge: Cambridge University Press, 1993) pp.135-156.

appearance of non-medical input, although they still held out successfully against patient membership.¹⁵

The wider geographical spread of services and reduced prominence of the London prescribing scene in treatment policy debates strengthened voices from the rest of the UK and diverted attention from private prescribing. This worked both for and against private prescribers: less attention was given to controlling their prescribing practices than was the case in the 1980s, but their scope for representation and participation in the policy process was also diminished.

The demise of AIDA, although never powerful, removed a conduit through which official representations could be made. In 1996, the similar Association of Independent Prescribers was set up, too late to influence the next round of clinical guidelines, and collapsing only two years later. The rise of local policy making on drugs issues and the marginalisation of private prescribers were both seen in the origins of the Association of Independent Prescribers. Instead of central government, as in the case of AIDA, it was local government and services that were the instigators, keen to see private doctors organized and self-regulating. However, like AIDA, they were similarly unable to protect it from internal conflicts and private doctors remained outside the policy community.

Through the 1980s and '90s further moves were made by NHS consultant psychiatrists to regulate private prescribers. These included attempts to encourage the Home Office to further restrict the prescribing of opiates and injectable drugs by GPs and private doctors. Changes in key civil servants, both medical and administrative at the Department of Health and Home Office, were initially more favourable to these regulatory aims but the ground gained by the harm reduction movement in the wake of the HIV/AIDS crisis and the continuing increase in drug users seeking treatment worked to counter this.

In a reversal of the anti-maintenance orthodoxy of the early 1980s, long term prescribing of oral methadone was seen as a way of enticing patients into treatment and keeping them away from the risky practice of injecting. Policy makers were fearful that the greater restrictions desired by the London NHS psychiatrists and civil servants could discourage reluctant GPs from involvement with these unpopular patients and they were not implemented. Meanwhile, the introduction of management into the NHS brought increased regulation, including clinical audit, within the whole

¹⁵ eg UK Health Departments, *Drug Misuse and Dependence. Guidelines on Clinical Management* (London: The Stationery Office, 1999).

National Health Service. Consequently by the 1990s the differential regulatory control over public and private drug doctors was more marked.

Two further editions of the 'good practice' guidelines were produced, with expanded contributions from general practice;^{16,17} these reflected the diminished concern about private prescribers, but the issue was still important enough to spur the writers of the third guidelines to propose a new system of prescribing controls, with particularly strict requirements for these doctors. By 1999 NHS drug services had become integrated into wider developments in health services, with emphasis on the 'primary care-led NHS' and 'evidence-based medicine'.

Although government attention fell directly on the public sector, by the end of the century the increased pressure on the GMC also increased scrutiny of *all* doctors. As the period closed, private prescribers' arguments had been subsumed within the wider concerns of health services, patient choice, and professional self-regulation and, unable to organise either as an effective lobby group or to self-regulate, their influence and very survival looked threatened.

Thematic Findings

Two main weapons were used to fight the battles over private and NHS prescribing, and to express differences of opinions between the different camps: the media and the various systems of medical regulation.

Regulation and the public-private relationship

Medical regulation has been described as a way of protecting consumers of services when the market place cannot or does not work due to unequal knowledge between consumer and supplier.¹⁸ Self-regulation in England has been based on the idea of professional consensus, lacking in the drugs field, particularly from the mid-1970s onwards, with the definition of 'good practice' highly contentious both among professionals and patients. In such a divided arena, regulation, both within the profession and by the state, was used repeatedly in attempts to control the range of drug services provided and the content of treatment, particularly in the 1980s and 1990s, with little basis in research evidence. The changing constituents of the drugs policy community interacting with wider developments in the health service and society at large produced a range of regulatory

¹⁶ Department of Health, Scottish Office Home and Health Department and Welsh Office, *Drug Misuse and Dependence. Guidelines on Clinical Management* (London: HMSO, 1991).

¹⁷ UK Health Departments, (1999) *op. cit.*

¹⁸ M. K. Duval and J. Den Boer, 'Consumer health education' in A. Levin (ed.), *Regulating Health Care. The Struggle for Control*, Proceedings of the Academy of Political Science, 33, 4 (New York: Academy of Political Science, 1980) pp.168-181.

effects across the period, combining state and self-regulation in varying combinations with different groups of doctors.

The thirty years under examination saw a number of regulatory interventions, both in changes to the existing framework through legislation and in the implementation of existing regulatory systems against individuals. The treatment of addiction was one of the earliest examples of state and professional supervision of prescribing practice when heroin and cocaine licences were introduced for doctors at the end of the 1960s and drug treatment was one of the first areas to develop guidelines on good practice in the 1980s. The role of private practice was pivotal in these regulatory developments and was still a significant influence in the 1990s.

The GMC, the Home Office Drugs Inspectorate, and the working parties which produced the clinical guidelines all formed part of the formal regulation of drug doctors, representing both state sponsored self-regulation and direct regulation by the state. Formal regulation did not equate with fixed rules but instead was flexible and beset by ambiguity. The GMC avoided issuing specific advice, definitions, or clear rules of conduct and this was exploited by particular factions wishing to use self-regulation for their own ends.

In the high profile disciplinary hearings against Ann Dally, the GMC showed an apparent bias against her but a conspiracy to drive her from practice was not proven. In the 1980s the system seemed to be used politically against non-conforming doctors. At the same time, under external pressure, the GMC had increased its scrutiny of practitioners' conduct. The profession had a poor record of concern for regulating the conduct of doctors in the treatment of patients, and during the 1970s and '80s, the rise of patients' rights and consumerism outside of the profession increasingly pressurised the GMC to address issues of clinical decision making, especially when it involved neglect, harm or death caused by practitioners.¹⁹ The 1980s and '90s saw a rise in disciplinary cases concerning doctors' conduct and the case of Dr Tamesby showed that the GMC did fulfil some role in protecting drug using patients from private prescribers whose practice was dangerous, however reluctantly.

The regulatory tools available to the Inspectorate, and their use, passed through several different phases over the period, interweaving with the GMC: 1970-73 was a period of frustration; the Tribunal system had passed into legislation in 1971 but was awaiting activation, with a GMC

¹⁹ M. Stacey, *Regulating British Medicine: the General Medical Council*, (Chichester: John Wiley and Sons, 1992) pp.173-199.

reluctant to take action itself; from 1973 to '82 the Tribunal system was used, but only occasionally, probably due to lay-medical sensitivities, while the GMC took some action itself. After 1982, the GMC continued to discipline private prescribers and the use of Tribunals became more frequent until the mid-1990s Garfoot 'watershed'. From 1997 the Tribunals fell into disuse, partly as a result of supra-national regulation and the step up in medical self-regulation, with the GMC taking over as sole prosecutor of 'irresponsible' prescribers and gathering momentum at the turn of the century. Although the Inspectorate and the GMC continued to co-operate, with the Inspectorate providing some of the information used for the GMC cases, the weight was on professional rather than state regulation.

During the 1990s the Inspectorate's leadership sought greater control over non-Clinic prescribers, but failed to protect its sources of strength, losing two regulatory mechanisms: the Addicts Index and the Tribunal system. By the end of the twentieth century, the Inspectorate was a much diminished force. After an initially heightened status as the main advisory source of ministers, it had failed to capitalise on the growing political importance of the drugs issue, losing out to other more specialised agencies and cost-cutting exercises. Other developments such as the government and media pressure on the GMC to increase its regulatory activity across all of medicine, and the questioning of doctors' ability to self-regulate, in addition to the costly failure of the Garfoot case and the end to Tribunals, left the Inspectorate dependent upon the GMC to enforce the findings of its much reduced inspections.

Throughout these three decades, the Inspectorate informally cooperated with the other strands in the regulatory network, both state and professional, to gather intelligence, and to advise and discipline those non-Clinic doctors it found wanting. Clinic doctors had managed to establish themselves and maintain a position of expertise that the Inspectorate did not directly challenge. No Clinic doctors were taken to Tribunal for irresponsible prescribing, and they were left to largely self-regulate.

Informal Regulation

Alongside these formal systems were informal ones which were less overt in their regulatory aims, but which also combined state and self-regulation. Three informal mechanisms were developed by the London Clinic doctors, private prescribers and NHS general practitioners with the encouragement of civil servants: AIDA (1981-1988), the AIP or Association of Independent Prescribers (1996-98) and the LCG (1968 to the present). Comparison of these three groupings using Cultural Theory has shown how and why the London consultants succeeded in fending off

outside regulation, and set the standards by which other doctors were judged, while the private doctors succumbed to extensive discipline.

In Cultural Theory terms, the private prescribers tended to be individualistic entrepreneurs (although this term does not necessarily imply a profit motive), scoring low on social stratification with considerable individual autonomy over behaviour and status. Their sense of group identity and boundaries with the outside were weak, meaning that there were few controls on who could become a private prescriber or a member of AIDA or the AIP. Economic competition within AIDA and also between AIP members, with attendant issues of commercial confidentiality, led to a lack of trust.

Cultural Theory would define the London consultants as a hierarchy, with a strong sense of stratification and identity as a group. There was competition between London consultants for prestige and resources, but not for patients, and although they too had rivalries and resentments, these were held in check for the sake of the overriding interest of group.

AIDA and the AIP both drew memberships from doctors working outside the Clinics. Unlike the LCG, they did not try to regulate other groups of doctors but intended to raise standards among their own members and defend themselves from attack. Neither AIDA nor the AIP reached their goals and both collapsed from insufficient support and interest. They lacked sanctions that could be applied to non-conforming members, other than expulsion, and so could not enforce their policies. However, the London Consultants Group also lacked formal sanctions but succeeded in influencing its own members' practice and wider policy, so what made the difference?

The patterns of involvement with the state and establishment bodies among these three groups affected their ability to influence prescribing policies and regulation. Individual personalities also played a role, but secondarily to the social organisation of the associations, the economic positions of their members, and their resulting values, priorities and perceived interests.

The London Consultants Group's strengths lay less in its own meetings than in members' perceived shared identity and their networks of mutual ties; bonds which integrated them both with each other and into establishment bodies inside and outside the state. Many of the LCG members also belonged to at least one of the GMC, Royal College of Psychiatrists, Advisory Council on the Misuse of Drugs, or government working groups, so they encountered each other across a variety of settings. From 1977 their meetings took place at the Home Office, a location they denied to

AIDA. In contrast, the private prescribers generally only saw each other at AIDA or the AIP, so rarely had other links with each other, and also lacked the membership of establishment bodies with the exception of the 1984 guidelines working group (see Chapter 4). While LCG members had a lot to lose from ongoing feuds with each other, AIP and AIDA members who rarely encountered each other in different occupational settings, felt they had less to lose by staying true to their own preferences. This also applied to the feud between private prescribers and London consultants who did not often encounter each other.

An ability to trust each other would give the members of a group an advantage in working together as information could be shared openly. As might be expected from a group with a greater sense of shared identity, the LCG drew a strong boundary against outsiders and there was less direct competition between members, fostering greater trust within the London Consultants Group than among the private prescribers. The latter's mistrust on confidential matters was borne out to some extent, as the author was able to access the papers of both the AIP and AIDA from the actions of single members acting alone in each case, whilst a lone member of the LCG felt unable to act without the consent of its current membership. The LCG succeeded in controlling information that dated back to the 1970s, across generations, despite the fact that it was not held centrally. The LCG's strong identity and sense of solidarity meant that an individual member did not feel able to act autonomously, but needed corporate permission to proceed, and its secrecy showed a strong boundary to the outside world.

What might be seen as the corporate weakness of the private doctors, they themselves would have prized as freedom to follow their own prescribing preferences independent of the peer pressure that affected the London consultants. Their independence, although helping them to resist both formal and informal regulation in the short term, weakened their claims to self-regulation, and ultimately led to a loss of freedom when forced to conform by formal regulation.

Klein, although not referring to Cultural Theory, has distinguished between individual and collective autonomy (weak and strong group) when discussing the introduction and implementation of clinical audit in the National Health Service. He saw this as the medical profession accepting and participating in the restriction of individual clinicians' autonomy in order to strengthen collective professional autonomy,²⁰ a similar process to that seen in the LCG.

²⁰ R. Klein, (1995) *op. cit.*, pp.243-244.

However, the conformity of the London consultants should not be over stated. Although they pushed through restricted prescribing for new Clinic patients in the late 1970s and 1980s, they retained considerable autonomy for themselves in dealing with established patients, and in the 1990s, they were offering a range of different treatments, including injectable prescribing, heroin, and amphetamines, at their own discretion while still attempting to prevent such practices outside of the Clinics.

Regulation of Patients

An unusual aspect of this area of medical practice was its role in controlling the supply of drugs. This tended to be couched either in terms of public health – preventing the spread of addiction – or crime prevention through curbing the illegal trade in pharmaceutical drugs. In the 1980s doctors' policing roles became more explicit through the actions of the GMC. The Inspectorate had prosecuted doctors for 'irresponsible prescribing' before this, but in 1983 the GMC made clear that it expected doctors to predict the likelihood of the drugs they prescribed being diverted to other users, holding Dr Dally to account for the sale of drugs that she might or might not have prescribed.

The conflicts this could bring between a doctor's concerns over a patient's health and his or her potential criminality or risks to public health were a recurrent theme in the prescribing debates. The regulation of doctors' prescribing was therefore also the regulation of patients' drug use. Recommendations for consumption of methadone doses to be supervised by pharmacists and picked up daily, for instance, aimed both at preventing individual binge use and overdoses and stopping supplies reaching unintended hands.

For private doctors particular conflict could arise over the non-payment of fees. In view of the concerns expressed by some over the effect of payment of fees on the doctor-patient relationship, it might be expected that a doctor would be considered unethical to cease a patient's treatment for non-payment, but the regulatory bodies concerns over the illicit sale of prescription drugs created a situation where a doctor was at risk of disciplinary action if he or she kept treating such a patient.

Role of the media

The interface between the media and medicine has been a complex one.²¹ In this debate the media acted as both a conduit for the views of both sides of the debate and as an actor in itself. The

²¹ K. Loughlin, "'Your Life in Their Hands': the context of a medical-media controversy', *Media History*, 6 (2000), 177-188.

medical press featured articles and letters from proponents and opponents of private prescribing, which were then fed into the regulatory process. The general media were also involved in the debate. As well as featuring letters from both sides, a number of 'stings' were carried out by undercover reporters posing as drug dependent patients to test the ease with which they could obtain drugs from private doctors. The resulting articles in the tabloid press prompted investigations by the Home Office Drugs Inspectorate and were also featured in disciplinary cases before the GMC. The stings continued into the 1990s and one by the *News of the World* in 1996 which encouraged a poor image of private prescribers acted as a spur to the creation of the Association of Independent Prescribers as a means of self-defence and improving their public profile.^{22,23}

Ways in which the private prescribers and the London consultants used the media pointed up some of the differences between them. Ann Dally, and later to a lesser extent Colin Brewer, wrote for and appeared in both the general and medical media; aside from one letter to *The Times* by a group of consultants and voluntary sector organisations written in 1981, Dr Dally's chief opponents, Drs Connell and Bewley, restricted their expressions to the medical press. Dally's very public attacks on the Clinics rarely received direct responses in the non-medical public sphere. Given the private, behind-the-scenes nature of much policy-making in drug treatment during the 1960s and '70s, drawing the debate outside medicine and into the public's gaze may have been seen by the London consultants as particularly reprehensible in the 1980s and '90s. The result was a more 'private' debate sought by the public doctors, who wished to keep the general public out of the issues, and a 'public' debate pursued by private doctors.

Of course, the two cases that brought Ann Dally before the GMC provoked a considerable amount of coverage in both the medical and general media. Bringing the prescribing debate to the general public also drew scrutiny of the Council's processes, seen by several commentators as unfair, and if her accusers wished to see a vocal critic silenced, the cases partly backfired.

The Policy-Making Process

Changes in the make-up of the drugs policy community have been described above, showing the influence of different professional groups and particular individuals, and reflecting the changing profile of drug treatment services in England. Throughout this period members of the policy community showed varying degrees of interest in regulating prescribing. Government politicians

²² M. Johnson, Interview by Sarah Mars, (2000).

²³ M. Johnson, Interview by Sarah Mars, (2001).

did not concern themselves with these details except for any implications for cost or overall service provision. Given Conservative governments' favourable attitudes towards private medicine, private prescribers might have expected some support. However, prescribing was not considered fodder for the party political debate on the public-private mix in health care provision, but rather as part of the cross-party 'drugs' issue and this dichotomy continued into the 1990s.²⁴

By contrast, civil servants at the Home Office and Department of Health took a keen interest in the prescribing debate and their shifting alliances with doctors influenced ventures to control prescribing outside the Clinics, and also the degrees of success these projects achieved. Key senior civil servants, both medical and lay, tended to be very knowledgeable about the drugs field and held private views on appropriate prescribing and how treatment services should be arranged which they did not openly declare but which guided the policies they initiated and pursued.

Methods used by civil servants to push forward their aims included briefings to ministers, encouraging ministers to fund particular types of services, provision of informal advice and information to clinicians, informal support for clinicians' own political activities, and particularly important in the prescribing debates, advice and support for expert committees, such as the ACMD, and the good practice guidelines working groups. As might be expected in a small policy community, changes in these key personnel in the 1980s and 1990s had significant impacts on attempts to control private prescribing.

While the Clinics formed the main response to drug problems in the early to mid-1970s and their prescribing was eclectic and often generous, they faced little opposition and generally co-existed with private alternatives outside. The medical profession dominated policy making bodies such as the ACMD and was either decisive in or genuinely consulted about policy changes. But once the London consultants had used their collective strength to move away from such prescribing across the board in the late 1970s and early 1980s, and NHS GPs were becoming re-involved in drug treatment, the consultants began to face competition and criticism from NHS GPs, private prescribers and voluntary services, who in turn gained support from key civil servants keen to see greater diversity of provision beyond the Clinics. London consultant leaders attempted to use both regulation by the state, in the form of the Home Office Drugs Inspectorate, and medical self-

²⁴ eg. NHS Executive, *Regulating Private and Voluntary Healthcare. A Consultation Document*, (London: Department of Health, 1999).

regulation through the GMC and clinical guidelines to weed out this opposition.²⁵ They also helped scupper one senior civil servant's attempts to link with private interests and build a new policy community.

When successfully allied, even if differently motivated, civil servants and consultant psychiatrists usually managed to increase regulation over other doctors during the 1980s. This happened with the production of the first good practice clinical guidelines (1984), which were subsequently used by both the GMC and Home Office in their disciplinary cases, and in disciplinary cases against particular private doctors. However, this did not give the consultants all that their leaders wanted: they had actually been seeking statutory controls over other prescribers and probably agreed to a civil servant's proposal of good practice guidelines as a compromise. Furthermore, consultants' attempts to give the guidelines sharper teeth through an extended licensing system failed when opposed by civil servants. Although powerful through existing routes of regulation, the London consultants were insufficiently influential at ministerial level to achieve change in legislation without the help of senior civil servants.

Equally, senior civil servants in the Home Office and Department of Health were not always supreme, and were aware of a number of constraints on their actions. In the 1980s, when the private-public battle was at its height, these civil servants trod a careful path to appear non-partisan, and were sensitive not to antagonise the powerful London consultants. The Inspectorate in particular, through the 1980s and '90s, was also sensitive to the potential conflicts of interest between regulating the doctors outside the Clinics and its role in encouraging doctors' involvement with this unpopular patient group and cultivating medical contacts for intelligence gathering.

During the 1990s, the balance between civil servants and the rest of the policy community changed. Major players at both the Department of Health and Home Office were intent on greater regulation of prescribing. Yet in the drug treatment field the voices of psychiatrists had not only to compete with other professionals, but also with general practitioners and public health doctors, all now inside the policy community. Post-HIV, the community response to drug problems was further strengthened and hospital doctors, although still clinging to the title of 'addiction specialists' had greater difficulty controlling what went on outside. In the late '80s and 1990s, there was greater accord in the policy community than during most of the 1980s, partly with the precarious harm

²⁵ S. Mars, 'Public versus private treatment for addiction: Britain in the 1980s', *Health Between the Private and the Public – Shifting Approaches*. European Association for the History of Medicine and Health Annual Conference, (Oslo, Norway: 3rd-7th September 2003).

reduction consensus, and also with the forced departure of vocal critic Ann Dally. These developments both helped and hindered the senior civil servants who were trying to gain greater central control over prescribing.

Overarching all these changes, the medical profession was under pressure to prove it could self-regulate and at the end of the century, in this atmosphere of increased scrutiny, the GMC prepared to mount a flurry of cases against private prescribers, which were to thin their numbers and deter those remaining from prescribing outside official guidelines.²⁶ Yet at the same time, London consultants failed once more to extend licensing to doctors outside the Clinics, even though this time they had gained the support of the necessary civil servants. By this stage, the Home Office Drugs Inspectorate, under Alan Macfarlane, had lost its pivotal position as drugs policy advisor to ministers, so its support for the proposals had less impact. At the same time, several vocal GP members of the policy community who opposed the licensing proposals had accrued more influence than their predecessors had held in the 1970s or '80s, both reflecting the increased importance of general practice in drug services and their raised status and power across the NHS.

The role of civil servants in the policy community was critical throughout this period, and demonstrated a complex relationship between the state and the medical profession that did not fit what might be called a Foucauldian model: according to such a model, the central government inspectorate might have been expected to have taken an impersonal approach to monitoring its subjects but the changing leadership of the Inspectorate showed the very personal imprint left on the surveillance and disciplinary processes. Far from seeking conformity, Spear encouraged heterogeneity in treatment services and regulatory methods, while making opportunistic alliances to achieve this. David Armstrong's Foucauldian concept of the 'Infirmary' fitted the Inspectorate's mode of working more closely than Foucault's original 'Panopticism', but did not add significantly to understanding the role of the Inspectorate.

The independent expertise that characterised the Inspectorate further developed Gerald Rhodes' findings of central government inspectorates' tendencies to diversify their roles to develop their own knowledge bases and act as advisors to ministers on policy issues. Rhodes also saw inspectorates as not only enforcing standards, but setting them too. This also matched the Home Office case and a similar division made by the inspectors between those they inspected on a

²⁶ eg. M. Johnson, Interview by Sarah Mars, (2000).

friendly basis to gather intelligence, who were considered reputable, and the dishonest who were prosecuted.

The characteristics of this Inspectorate corresponded to a Weberian model of bureaucracy, where power was derived from technical expertise and knowledge developed through experience in the service, as did its tendency to self-perpetuate into a permanent institution through adapting its aims, rather than serving the ends for which they were originally designed. The Drugs Inspectorate developed into a source of policy advice for government, training for prescribers, an occasional referral agency for patients, and policy actor in its own right.

Spear's behind-the-scenes involvement with AIDA and invitation to host its meetings at the Home Office conformed to a pattern found elsewhere by Virginia Berridge with the pressure group Action on Smoking and Health. In both cases the government was supporting voluntary organisations who could advocate policy positions desired within government but not deemed acceptable or advantageous for government to express itself.²⁷

The roles of private prescribers and NHS psychiatrists in the policy community have been discussed but the contribution of GPs was also important. Through most of the 1970s, GPs had been excluded from treating drug users to the delight of some of their number²⁸ and their re-involvement later on in that decade was led by grass-roots patient demand rather than government or professional policy. Their representation in the policy community was initially weaker than the London consultants, but it grew through the rest of the century, reflecting their increased numbers in treatment services, their rising status within the medical profession, and after the *Treatment and Rehabilitation* report of 1982, official Department of Health policy that encouraged their participation. Although more integrated into the state than private prescribers, as contractors to the NHS they were nonetheless more independent than the salaried psychiatrists and shared some of the interests of each. By the late 1990s, some GPs in the policy community were acting as proxies for the excluded private prescribers, fearing that the proposed changes affecting both groups of doctors could increase centralised controls bringing a loss of autonomy from themselves and their patients.

²⁷ V. Berridge, 'Issue network versus producer network? ASH, the Tobacco Products Research Trust and UK smoking policy' in V. Berridge (ed.), *Making Health Policy: Networks in Research and Policy After 1945* (Amsterdam: Rodopi, 2005) pp. 101–124.

²⁸ A. J. Hawes, 'Goodbye junkies. A general practitioner takes leave of his addicts', *Lancet* i (1970), 258–260.

With greater GP involvement and the diminishing impact of private practice in the policy community, the debate over the appropriate prescribing moved from the language of 'public' versus 'private', and 'inside' or 'outside' the Clinics characteristic of the 1980s, to one increasingly expressed through a distinction between 'specialists' and 'generalists' in the 1990s. The specialist-generalist differentiation was used in Home Office disciplinary proceedings at this time and was a major subject of debate in the 1999 guidelines working group meetings, using training and experience as the measure of specialism, rather than specialty or location of work. This partly reflected wider changes in Department of Health policy for the NHS, with its promotion of 'shared care' between specialist and primary care and a 'primary care led' NHS, but essentially came down to the same fundamental issues: the control of particular prescribing practices outside the Clinics.

The drugs policy community has shown many parallels with the alcohol policy community, as described by Betsy Thom, where many of the same developments were seen at an earlier point in time. These included a powerful institutional and professional base within psychiatry in the Maudsley hospital, with strong bonds to medical civil servants in Ministry/Department of Health. Both sets of medical experts (sometimes the same people in alcohol *and* drugs) adhered to a medical disease model, which gave way to a more social and behavioural model in the drugs field in 1980s and in alcohol a decade earlier. Both saw a widening of the policy community, but with a strong position retained by the psychiatrists into the 1990s. Concepts moved in both directions, with the 'problem drinker' generating the 'problem drug taker' in the early 1980s, and support for 'harm reduction' in the drugs field being used to gain support for a similar approach in the 1980s and 1990s for alcohol policy.²⁹

Although the move from the disease model of alcohol 'dependence' to the more behavioural model of 'problem drinker', influenced by psychology, might seem to have reduced the role for medicine by necessitating input from the other professions and voluntary services, Betsy Thom has suggested that in the alcohol field this change also opened up new approaches for psychiatry.³⁰ A very similar effect could be seen in the drugs field with the change from drug dependence to 'problem drug taker', the term introduced by the ACMD,³¹ both normalised and re-pathologised drug users: on the one hand it suggested that not all drug users had problems resulting from their drug use requiring medical or other care. On the other it widened the pitch so that addiction was

²⁹ B. Thom, *Dealing with Drink. Alcohol and Social Policy: From Treatment to Management* (London and New York: Free Association Books, 1999) p.217.

³⁰ *Ibid.* pp.149-151.

³¹ ACMD, (1982) *op. cit.*, p.34-35.

not the limit of drug problems that medical services might need to address, extending them to regular excessive consumption and intoxication.

The terms 'public' and 'private' have an additional meaning in terms of policy making, relating to spheres, rather than ownership. Stimson and Lart have described policy making visible in the drugs field in the 1960s and the 1970s as carried out behind the scenes in 'an essentially private world where policy was made by accommodation between experts and civil servants'. The ACMD, established in 1971, continued in this tradition,¹² and its discussions and minutes were subject to the Official Secrets Act.

In the 1970s, policy changes among the London consultants, such as the switch from heroin to methadone prescribing, took place through committees (the LCG) which met in private and in discussions at medical conferences, rarely involving public campaigns. Treatment policies were seen as a private affair, and it is the conclusion of this research that it was the public nature of Ann Dally's attacks on the Clinics that so embittered the London consultants as much as the content of the attacks themselves. Discussing in public what the London consultants saw as matters for private, or at least confined to the profession, broke their code of private policy-making.

Others, such as Dr John Marks, consultant psychiatrist in a Liverpool DDU, famous for his advocacy of substitute heroin prescribing, and Dr Colin Brewer, a London private prescriber who was briefly a member of AIDA and the AIP, continued in a similar vein in the late 1980s and '90s, and gained similar unpopularity with the Clinic establishment. Although doctors' prescribing differences had been brought fully into the spotlight of the general media, not all policy issues were dealt with in public after this. Aside from the rhetorical debates about issues such as links between drug dependence and acquisitive crime, much of drugs policy continued to be made in private meetings between doctors and civil servants. The licensing issues of 1984 and 1999 were dealt with largely within the policy community and the committees' licensing recommendations went directly to ministers. The '99 *Guidelines* made only a brief mention of these intentions.

International influences

The freedom from legislative controls enjoyed by doctors in the 'British System', even after the changes of 1968, was distinctive among most Western countries, where substitute prescribing was either non-existent or highly controlled. And although Britain was often held up as a model in the

¹² G. V. Stimson and R. Lart, 'The relationship between the state and local practice in the development of national policy on drugs between 1920 and 1990' in J. Strang and M. Gossop (1994) *op. cit.*, pp.331-341, p.336.

United States, the influence went in both directions. The switch from heroin prescription to methadone in the 1970s and '80s in the London Clinics was partly due to pioneering work in the US observed by NHS psychiatrists visiting from England. Later, in the 1990s when 'evidence based medicine' came to the fore, international research became more prominent in the debate. There was some indication, for instance in relation to heroin and methadone prescribing in the 99 *Guidelines*, that evidence was cited selectively to support existing preferences while equally robust research was ignored, but a more systematic analysis beyond the scope of this study would be required to confirm this.

Different models of medical practice

The most appropriate and professional model of care for prescribing to drug users, held up by the London psychiatrists, was that of the salaried hospital doctor. After 1982, NHS GP practice could also be acceptable, but single-handed practices were criticised within the NHS. Private prescribing, especially by a lone practitioner with none of the multidisciplinary support of the Clinics or GP group practices, were deplored by influential addiction consultants.

Financial encouragement of group general practices and health centres across the NHS had followed the 1966 new contract,¹³ and working alone gradually became seen as outmoded in the NHS. Some criticism of private practitioners could be seen as part of the dominance of newer health service models over the old style of single-handed practitioners, also reflecting medicine's accommodation of other occupational groups.

Further insight can be drawn from the reverse situation found by Stuart Anderson in pharmacy, where conflict over models of working was also part of policy debates. Among pharmacists, salaried professionals, such as those employed in hospitals, were in the minority and less well organised, while the small business model of community pharmacy dominated in number and influence. The tension between pharmacy as a profession and pharmacy as business was a major theme, and under the welfare state it was the business model that tended to triumph in the latter half of the twentieth century.¹⁴ This contrast between doctors and pharmacists has suggested that it may have been the position of particular groups of professionals within their professions, and their degrees of representation in their professional bodies that determined the success of their favoured models and arguments, rather than any intrinsic merits of their particular cases.

¹³ C. Webster, *The National Health Service. A Political History* (Oxford: Oxford University Press, 1998).

¹⁴ S. Anderson, 'Health professionals and health care systems: the role of the state in the development of community pharmacy in Great Britain 1900 to 1990', *National Health Policies in Context Workshop*, (Bergen, Norway, 27-28th March 2003).

Consumerism in health care

Consumerism in health was a strengthening force throughout this period but was notably absent from the development of NHS drug treatment services, and private doctors argued that they responded to patients' needs by providing a greater diversity of options. Equally it has been argued that the nature of addiction compromised patients' free will and ability to exercise self determination; that what such patients 'wanted' was different from what they 'needed' and a financially disinterested doctor was needed to distinguish the two.

Sociologist Terence Johnson considered that there were contradictory processes at work within the development of a profession, one set of opposing forces was found between occupational control ie from within the medical profession, and consumerism – control by the client. Consumer choice introduced pressure towards diversity in the occupational community which counter-balanced occupational control.³⁵ These forces could be seen struggling against each other in the battle over prescribing between the private doctors and the London psychiatrists. The strength of the consumer varied over the period in relation to doctors, depending upon factors such as the range of alternative services and the desire of health services to attract patients for instance to prevent HIV/AIDS, but overall, these patients' stigmatised status and poor collective organisation left them without a strong voice to influence provision. The patient activist groups that emerged were notably absent from expert committees such as the ACMD and all three clinical guidelines working groups. To some extent, the voluntary sector and occasionally particular GPs, have taken on the role of 'patient advocate' within the policy community.

The Clinics' prescribing changes in the late 1970s took a paternalist approach using a more 'confrontational' attitude to patients – one that the patients would not necessarily choose themselves – while the private doctors offered some of the services that the Clinics had withdrawn and gave greater autonomy to patients. At the same time, such views also represented different medical responses to consumerism in health – the duty to the individual or the wider role of regulating the flow of drugs in society.

This split could also to some extent be seen within the NHS between psychiatrists and public health doctors on the one side, and GPs on the other, for instance in debates over the supervised consumption of methadone in the late 1990s. GPs on the *'99 Guidelines Working Group*, though not

³⁵ T. J. Johnson, *Professions and Power* (London and Basingstoke: Macmillan Press, 1972).

typical of general practice in general, seemed to be the advocates of greater autonomy and less central control, showing more trust in their own judgement and that of their patients, while those centrally employed, such as the psychiatrists and public health physicians, put their trust in central government and doctors who, like themselves, had received more extensive formal training. Explained in terms of Cultural Theory, one would expect the independent entrepreneurs (private prescribers, and to varying degrees, GPs) to share a distrust of central control in contrast to the hierarchical state-employed professionals and to value informal personal judgement over formally developed systems of accreditation, such as post-graduate specialist training, and this was borne out by the findings.

It was noted in the 1980s that in the medical and general media the debate about the roles of public and private doctors and of specialists and generalists 'included very little on the views of addicts themselves'.³⁶ This was found to be the case in this research during all three decades. Occasionally a letter would be published in the press from a drug user, but this was the exception.³⁷ Ann Dally attempted to give private patients a voice in the debate when she started up the Alba Association³⁸ but it failed to flourish. Other drug user groups active in the 1980s were allocated funding from a BBC appeal,³⁹ but also fell by the wayside. A number of user groups emerged in the late 1990s and these began to receive official recognition and support. At the same time, resistance to their influence persisted, for instance, from within the Home Office's Drugs Inspectorate,⁴⁰ and from some addiction psychiatrists.

Treatment and Drugs Supply Control

In 1916 medical prescription requirements and criminal justice penalties were added to the system of pharmaceutical and state control over cocaine and opium, setting up an enduring tension between medicinal and policing concerns about 'narcotics'. The Home Office Drugs Inspectorate played a key part in seeking to balance the two according to its own changing priorities over the century.

From the outset the Clinics were set up to centralise and establish under licensed state supervision the medicinal use of controlled drugs from the less regulated prescribing of independent GPs and

³⁶ T. Bennett and R. Wright, 'Opioid users' attitudes towards and use of NHS clinics, general practitioners and private doctors', *British Journal of Addiction*, 81 (1986), 757-763, p.758.

³⁷ eg. A. B. Robertson, 'Prescription of controlled drugs to addicts' [letter], *British Medical Journal* 287 (1983), 126.

³⁸ A. Dally, (1990) *op. cit.*

³⁹ D. Turner, *Interview by Sarah Mars*, (2002).

⁴⁰ Senior Home Office Official, *Interview by Sarah Mars*, (2002).

private doctors. Early on, the state, in the form of the Ministry of Health, tried to influence prescribing policies at the Clinics, but was rebuffed. The Clinics were entrusted with the tasks of controlling the spread of addiction, undermining the black market, and ministering to individual patients' physical and psychological health, aims which could conflict, and which did not always suit their aspirations as an emerging professional specialty.

Similar problems faced drug doctors outside, whose own priorities could be at odds with the Inspectorate or from the 1980s, the GMC's views on controlling the drug supply. The Inspectorate expected drug doctors, and particularly those in private practice, to incorporate a range of policing practices into their medical work to detect any diversion of drugs by patients to other users. Rulings made by the GMC in the 1980s for the first time held a doctor responsible for the ultimate fate of drugs prescribed to a patient. In this the GMC absorbed into its code of ethics the criminal drug control concerns of the Inspectorate as a tool to distinguish between the acceptable and unacceptable treatment of addiction outside the Clinics. This reflected the need of Clinic elements within and around the Council for an alternative measure of competence as part of their professionalizing strategy in a field where relatively low levels of technical skill were required by practitioners and outcomes were hard to measure or even agree upon.

It is important to note that the division between the priorities of drug control and treatment did not correspond neatly with the Home Office on the one side and the Department of Health on the other. The Home Office Drugs Inspectorate had a long history of concern about treatment provision both overall and for individual patients, and the Department of Health at certain points pushed for greater control over the drug supply. The Home Office was therefore a guardian of liberalism in health policy in the 1970s and '80s.

Bureaucratic and medical expertise

Across the three decades studied, sensitivities persisted between medical and non-medical expertise. Relationships between bureaucratic and medical members of the policy community involved intricate step-work in the regulation process. The Home Office Drugs Inspectorate, while possessing extensive knowledge and experience, included no doctors on its staff. This was a potential weak point in its own eyes, prompting its support for the production of good practice guidelines, which could be used by its Inspectors as a tool of state regulation under the cloak of medical self-regulation during the 1980s. Similarly, in the 1990s, its further aims to regulate doctors outside the Clinics were pursued through the forum of the medically dominated 99 *Guidelines* working group.

While the Inspectorate's official remit was to keep prescription drugs within authorised channels, and it advised doctors outside the Clinics accordingly, inspectors were wary of appearing to give medical guidance and seemed to avoid advising the Clinic doctors entirely. Some doctors outside the Clinics, although already prescribing to drug users, knew very little about the subject and for them the Inspectorate was a welcome source of unofficial and rarely acknowledged training in a dearth of other sources. During the 1970s and '80s there was very little time spent on addiction in the undergraduate medical curriculum and little opportunity for training for postgraduates other than psychiatrists specialising in addiction.

Role of research evidence in policy

Research evidence was significant in the public-private debate both for its misuse and its absence, at least until the late 1990s. Key pieces of research assumed prominence in the debates on treatment and have given validity to 'good practice' in the NHS. The Hartnoll-Mitcheson research of the 1970s justified changes away from predominantly heroin prescription towards oral methadone that became the NHS norm, despite the equivocal nature of its findings which were acknowledged when they were eventually published.⁴¹ While private doctors complained about the misuse of research by the opposition,⁴² they did not supply any alternatives themselves, relying only on their own experience and the testimony of patients.

From the 1970s to early '90s, 'expert committees', such as the ACMID and the first good practice guidelines working group almost entirely relied upon informal evidence and their reputations to support their statements. In this polarised field, the idea of impartial expertise was particularly problematic. When the evidence based medicine movement had gained strength in the 1990s, and was promoted by the Department of Health across medicine, and in the drugs field through its commissioning and review of research,⁴³ the clinical guidelines took on a new form, extensively referencing research studies. However, like the role of 'expertise', 'evidence based medicine' could be used as a legitimising banner under which a complex range of decision making and negotiating took place within a committee, with compromise recommendations made to reconcile conflicting research findings and reach consensus.

⁴¹ R. Hartnoll, M. C. Mitcheson, A. Battersby *et al.*, 'Evaluation of heroin maintenance in controlled trial', *Archives of General Psychiatry*, 37 (1980), 877-884.

⁴² A. Dally, (1990) *op. cit.*, pp.67-68.

⁴³ eg. Task Force to Review Services for Drug Misusers, *Report of an Independent Review of Drug Treatment Services in England*, Department of Health (London: The Stationery Office, 1996).

Prescribing policy was determined by personal preferences, on-the-job experience and political beliefs in the 1970s and '80s rather than by research findings and the research carried out was used to support these viewpoints regardless of its findings or methodologies. Even with the evidence based medicine movement in the mid and late 1990s, policy still seemed to lead the way ahead of research findings. The *'99 Guidelines* were not a radical break with the old tradition of expert committees or previous guidelines and themselves stated that they were 'primarily based on evidence obtained from expert committee reports and the clinical experience of respected authorities.'

This research has shown the mechanisms by which the London psychiatrists and opponents of private prescribing have dominated medical regulation both formal and informal between 1970 and 1999. The structures of doctors' own organisations and their alliances with parts of the state were crucial in the processes of the debate and resulting battles, but there were limits too on the dominant doctors' influence when seeking legislative change, which required the agreement of politicians who considered pressures from both inside and outside the policy community.

Changes in the drugs policy community over the period worked both for and against private prescribers. The loss of a key ally in the Home Office Drugs Inspectorate coupled with the disciplining and exit of the leading voice of private prescribing in the latter 1980s were counter-balanced by the emergence of harm reduction as an official policy, an alternative to abstinence based approaches favoured by the Clinics. On the wider stage, from the early 1980s health services were moving out of the hospitals and into the community, gaining closer ties with an increasingly state funded voluntary sector, thus diversifying the policy community. By the 1990s, private prescribing issues had become a side issue, both cooling down the debate, but also reducing private doctors' representation in policy circles. Attempts to redress this and encourage greater self-regulation through the late 1990s' Association of Independent Prescribers went the same way as its predecessor, AIDA, blighted by a lack of cohesion among its individualistic, competitive and untrusting membership. Overshadowed by the increasing density of NHS drug services outside the South East, London drug doctors' conflicts were seen as a purely metropolitan concern. In the years to follow, the private prescribers were to face the threat of Home Office licensing and decimation from a re-invigorated General Medical Council.

Appendix A Interviewed Doctors' Professional Roles (Interviews conducted between 2000 and 2003)

Table A1 Specialism and sources of funding by individual doctor

Doctor interviewed	Private GPs	Private addiction psychiatrist	NHS GP	NHS drug addiction psychiatrist	NHS non-addiction psychiatrist
Dr 001	✓			✓	
Dr 002 (retired)	✓				
Dr 003	✓				
Dr 004	✓				
Dr 005	✓		✓		
Dr 006			✓		
Dr 007		✓		✓ (previously)	✓ (previously)
Dr 008		✓		✓ alcohol addiction psychiatry, previously)	
Dr 009			✓		
Dr 010		✓			
Dr 011	✓		✓		
Dr 012		✓		✓	
Dr 013		✓			✓
Dr 014	✓				
Dr 015 (retired)				✓	
Dr 016			✓		
Dr 017		✓		✓	
Dr 018				✓	
Dr 019			✓		
Dr 020 (retired)	✓				

Doctor interviewed	Private GPs	Private addiction psychiatrist	NHS GP	NHS drug addiction psychiatrist	NHS non-addiction psychiatrist
Dr 021 (retired)				✓	
Dr 022				✓	
Dr 023			✓		
Dr 024				✓	
Dr 025 (retired)				✓	
Dr 026 (retired)				✓	
Dr 027				✓	

Table A2 Numbers of doctors funded from different sources

Roles of doctors interviewed (n=27)	Working at time of interview either privately or in NHS.	Retired at time of interview	Totals
Solely Private GPs	3	2	5
Solely NHS Addiction Psychiatrists	4	4	8
Solely NHS GPs	5	0	5
Solely Private Addiction Psychiatrists	1	0	1
NHS and Private GPs	2	0	2
NHS and Private Addiction Psychiatrists	4	0	4
Private addiction psychiatrists and NHS non-addiction psychiatrists	2	0	2

Appendix B: Timeline of Major Events

- 1965 Publication of second Brain report recommending tighter controls on prescribing and the establishment of specialist treatment centres (drug dependency units — DDU's or 'the Clinics'). (Virtually all recommendations implemented, except compulsory treatment.)
- 1966
- 1967 Dangerous Drugs Act (licence requirements for doctors prescribing heroin and cocaine)
- 1968 Implementation of 1967 licensing requirements for prescribing heroin and cocaine. Requirement for doctors to notify patients to the Home Office Addicts Index if they were found to be dependent on opiates or cocaine.
- 1968 First meeting of the London Consultants Group brought together by the Ministry of Health.
- 70 Treatment of drug users moved into specialist services in new Drug Dependency Units
- 1969
- 1970
- 1971 Misuse of Drugs Act, re-instituting Home Office Tribunals to regulate doctors' prescribing of controlled drugs.
- 1972
- 1973 Home Office Tribunals came into operation.
- 1974 White Paper 'Better Services for the Mentally Ill' proposed multidisciplinary services for drug users.
- 1975 ACMD set up a working group to produce a report on treatment and rehabilitation.
- 1976
- 1977 Interim report produced by on treatment and rehabilitation by ACMD' working group.
- 1978
- 1978/79 Large quantities of trafficked heroin start entering Britain. Trafficked heroin begins to take the place of diverted prescribed/pharmaceutical opiates as cheaper and more plentiful. Number of (opiate and cocaine) addicts notified to the Home Office began to rise more steeply.
- 1980 First published attack on private prescribers by a doctor.¹
- 1981 Dr Ann Dally started the Association of Independent Doctors of Addiction (AIDA) (independent meaning doctors outside the NHS Clinics).
- 1982 Radio Four broadcast sensationalist item 'Dr Death' and article in the Listener about private prescribers.

¹ T. H. Bewley, 'Prescribing psychoactive drugs to addicts', *British Medical Journal*, 281, (1980), 497-498.

- ACMD' final *Treatment and Rehabilitation* report was published calling for multidisciplinary team working and recommended strict controls on prescribing by doctors outside specialist services, particularly private prescribers. It recommended drawing up of 'guidelines for good practice' and the addition of dipipanone to heroin and cocaine licensing requirements. Also heralded expansion of drug treatment to re-involve primary care.
- 1983 January: Norman Fowler (Secretary of State, DHSS) called a meeting of the medical profession to consult them on the recommendations of the ACMD' *Treatment and Rehabilitation* report.
- Conservative Government announced its Central Funding Initiative to fund local projects for treatment and rehabilitation of drug users, stimulating the growth of the voluntary sector.
- British Medical Journal* published Bewley and Ghodse article 'Unacceptable face of private practice' and debate follows on the letters page.
- First GMC hearing against Dr Ann Dally, President of Association of Independent Doctors of Addiction.
- BMJ* published anthropologist Angela Burr's article identifying private prescribers and NHS GPs as source of blackmarket opiates in London.
- British Journal of Addiction* published Angela Burr's article on 'The Piccadilly Drug Scene' describing sources of illicit drugs that include private doctors' prescriptions.
- 1984 First clinical guidelines for the treatment of drug misuse published and circulated to doctors.
- Addition of dipipanone to licensing requirements (Misuse of Drugs Regulations)
- 1985 First comprehensive government strategy document on drugs policy published *Tackling Drug Misuse*.
- Discovery of high HIV prevalence in Edinburgh and Dundee injecting drug users.
- Home Office decided against extending licensing to all opioid prescribing.
- 1986 Second GMC case against Dr Ann Dally.
- Drugslink* published Mike Ashton's two-part article 'Doctors at War' about the Ann Dally GMC case.
- McClelland Committee of Scottish Home and Health Department recommended the establishment of needle exchanges in Scotland.
- 1987
- 1988 ACMD's *AIDS and drug misuse. Part I* was published recommending development of community drug services encouraging GP involvement and endorsing harm reduction. AIDA's last meeting.

- 1989
- 1990
- 1991 Second edition of the clinical guidelines published.
British Journal of Addiction published David Curson's editorial on private treatment of alcohol and drug problems in Britain, commentary and subsequent letters.
- 1992
- 1993 Home Office start proceedings for Misuse of Drugs Tribunal against Dr Adrian Garfoot.
- 1994 *Tackling Drugs Together* Green Paper published by the Conservative Government. Included section arguing against changes to the laws on drugs.
- 1996 Working Party responsible for producing third edition of Clinical Guidelines on drug misuse and dependence formed.
 December: First meeting of the Association of Independent Practitioners in the Treatment of Substance Misuse (AIP).
- 1997 Closure of Home Office's Addicts Index
 AIP produced draft guidelines for private prescribers.
 Replacement for Addicts' Index (Addicts Central Enquiry System) proposed by the AIP to be established in private practices.
 Dr Adrian Garfoot overturned Misuse of Drugs Tribunal ruling on appeal. End of Tribunal system.
- 1998 Home Office wrote to private prescribers about methadone related deaths stating that, 'Private prescribing has been identified by the Coroner as a significant factor'.
 Demise of Association of Independent Practitioners in the Treatment of Substance Misuse (AIP).
- 1999 Third edition of clinical guidelines published, including proposals for extending system of licensing for prescription of controlled drugs, with extra measures for private prescribers.
 Dispute between John Strang *et al.* (NHS opponents of private prescribing) and Colin Brewer (major private prescriber) in letters pages of *BMJ* regarding opiate detoxification under anaesthesia. Strang *et al* apologised to Brewer on *BMJ* letters page.
 Home Office sent 1999 edition of the clinical guidelines on the treatment of drug use to private prescribers. (NHS practitioners received copies from Department of Health).

Appendix C: Permission Form

The History Group

Oral History Records

Sarah Mars and Professor Virginia Berridge

**The Public/Private Relationship in Historical Perspective: The Treatment of
Addiction, 1970's-1990's**

FUNDED BY THE ECONOMIC AND SOCIAL RESEARCH COUNCIL

CLEARANCE NOTE FOR TAPED INTERVIEWS

The purpose of this agreement is to allow use of your taped interview for research purposes.
Please fill in this form according to your wishes.

I hereby assign the copyright in my contribution to the History Group of the London School of
Hygiene and Tropical Medicine.

Signed.....Date.....

Address.....
.....

[Tick ONE of the following options:]

I permit use of my name with quotes from the interview/s ☐

I would prefer any quotes from the interview/s to be checked with me before they are attributed ☐

I prefer quotes from interview/s to be used anonymously ☐

If you have any further instructions you may add them here:

.....
.....
.....

Appendix D: Glossary

Addiction/dependence: addiction and dependence are terms that have been subject to considerable controversy in the twentieth century. The changes in usage and meaning will be discussed in the thesis but are used interchangeably in this document to mean that the user of a drug is defined by a doctor as having adapted to its presence and would suffer if it were withdrawn abruptly.

Clinic: Colloquial name for the hospital-based Drug Dependency Units (DDUs) set up in the late 1960s and early 1970s.

Controlled drugs: Drugs controlled under the Misuse of Drugs Act, 1971. This included heroin, cocaine, methadone, amphetamines and benzodiazepines. This term replaced 'dangerous drugs' which was used in 20th Century domestic legislation until 1971.

Drug: in this context a drug is a psychoactive substance used in either an illegal¹ or unsanctioned way. This would include heroin, cocaine, solvents and tranquillisers, but for convenience excludes alcohol and nicotine.

Drug doctors: this term is used to denote any doctor with significant involvement in treating drug related problems. The term 'addiction doctor' can be misleading, as not all the drugs involved are addictive, and some of the patients are not treated for addiction but for other drug-related problems. The term does not imply the prescribing of substitute drugs, although this may be involved.

Methadone: synthetic opiate, also known as *Physeptone*, used to prevent withdrawal symptoms in opiate addicts. It is most commonly prescribed as an oral liquid but it also comes in an injectable form and as oral tablets.

Opioid: this term covers both derivatives of the opium poppy such as morphine and heroin ('opiates'), and pharmacologically similar synthetic substances such as methadone.

Private prescriber: a doctor paid by fee outside the NHS who prescribes substitute drugs (opiates, stimulants and tranquillisers) to patients for the treatment of addiction. He/she may be a general practitioner or have specialist training in addiction psychiatry.

Substitute prescribing: is usually used to describe the prescribing of one drug to replace another, such as methadone for heroin. However, here it also describes prescribing the same drug, such as heroin, as it is often intended to replace or obviate the need for a trafficked supply of the drug.

Trafficked drugs: A term used in the 1980s and in this thesis to differentiate between pharmaceutically produced substances obtained legally or illegally by users, and drugs smuggled or 'trafficked' into Britain from producer countries.

¹ According to the Misuse of Drugs Act, 1971.

Appendix E: Abbreviations

ACMD	Advisory Council on the Misuse of Drugs
AIDA	Association of Independent Doctors in Addiction
AIP	Association of Independent Prescribers, later termed the Association of Independent Practitioners in the Treatment of Substance Misuse
CFI	Central Funding Initiative
DDU	Drug Dependency Unit (colloquially known as a 'Clinic')
DH	Department of Health (the Department of Health split from the Department for Social Security in 1988).
DHSS	Department of Health and Social Security (formed by a merger of the Ministry of Health with the Ministry of Social Security in November 1968).
GMC	General Medical Council
GP	General Practitioner (NHS or private)
Inspectorate	Home Office Drugs Inspectorate
ISDD	Institute for the Study of Drug Dependence
LCG	London Consultants Group
PCC	Professional Conduct Committee (of the General Medical Council)
PPC	Preliminary Proceedings Committee (of the General Medical Council)
SCODA	Standing Conference on Drug Abuse
script	prescription
<i>T&R</i>	<i>Treatment and Rehabilitation</i> report of the Advisory Council on the Misuse of Drugs, London: HMSO, 1982.
Tribunal	Home Office Misuse of Drugs Tribunal

Appendix F: Bibliography

Due to the contemporary nature of the debate, it is not appropriate to divide the materials used into primary and secondary sources. All 'secondary' sources also have potential to be primary sources, being created in or around the period studied. Documents listed as in a 'private archive' are those either loaned or given to the author by interviewees during the research project and not held in formal archives. Most of the individual sources of these private documents are not named for reasons of confidentiality.

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