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Guest editorial

Tackling the drug problem – what can doctors do?

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In the course of the twentieth century, doctors have become gatekeepers to many drugs which people had previously been free to consume with little or no restriction. Britain is a signatory to the Single Convention on Narcotic Drugs (1961) and the Convention on Psychotropic Substances (1971) and is thereby required to "limit to medical and scientific purposes the cultivation, production, manufacture, export, import, distribution of, trade in, use and possession of [certain defined] drugs." This control is achieved through the Misuse of Drugs Act (1971) and Regulations (1985). Through these mechanisms, drugs such as cannabis, LSD, coca leaf and opium are completely debarred, whilst others with recognised medical indications but high abuse potential are stringently regulated.

This legal apparatus underpins the "War on Drugs" which aims to suppress all "recreational" drugs except alcohol and tobacco. Despite an immense cost in money and manpower, it has proved a singularly unsuccessful undertaking. Adulterated street drugs of unpredictable potency remain easily accessible to anyone who wishes to use them. Recent surveys suggest that almost a quarter of 15-year-olds have tried solvents or illegal drugs.[1] The compulsive use of heroin and cocaine is on the increase.[2] Incalculable profits flow year upon year to the organised criminals who vigorously exploit the demand. Much of the spiralling petty crime which afflicts us is driven by the need to obtain money for drugs.

Should some or all of the currently forbidden drugs be made available legally to those wishing to use them? The arguments on both sides of the legalisation and prescribing debates[3–8] have become depressingly familiar but have not yet progressed far beyond the sphere of vested interest.

Dreams of eliminating drug use are just that: dreams. History teaches that there has never been a race or civilisation which has not resorted to mind-altering drugs, nor have attempts at suppression ever been successful, no matter how Draconian the penalties imposed.[9] After decades of prohibition it is still possible to buy heroin and cocaine on the streets or in the pubs of any town in England, and at a price which is less in real terms than that of ten years ago.[10] Average purity has remained constant or even increased.[10] Proscription of alcohol in the United States between 1919 and 1933 demonstrated clearly that any personal health benefits of prohibition are outweighed by the social repercussions. Promotion of self-control through effective education and informal peer pressure, alongside measures to alleviate the social conditions which foster harmful drug use, is a realistic alternative to coercion by the state.

Most compulsive users of heroin and cocaine do not simply give up if their drug of choice becomes scarce or more expensive. They either switch drugs, sometimes to more toxic synthetic alternatives, or increase their criminal activities. Forcing people to obtain their drugs illegally binds them into a subculture based on crime and prostitution which is detrimental to both individual and public health. Prohibition will delay or even prevent drug use by some people, but the risks are made much greater for those larger numbers who are not deterred.

The distinctions between the legal and illegal recreational drugs are based on little more than quirks of history.[9] Political expediency and professional self-interest have played an important role. None of the forbidden drugs, if pharmaceutically pure, can match the awesome toxicity of cigarette smoke, or the domestic and public devastation associated with misuse of alcohol. Any relaxation in the control of forbidden drugs should be mirrored by a reduction in the marketing and points of outlet for cigarettes and alcohol.

There is scant political will for any change in policy at the moment, but doctors have it in their power to exert an immediate and powerful influence through the way in which they interpret their gatekeeper role. It is currently permissible for any doctor to prescribe any drug except heroin, cocaine or dipipanone (Diconal) to any addict, but very few are prepared to do so. Is this an attitude which can be defended from either a moral or logical perspective?

It is often said that addicts only have themselves to blame, but this sets a sinister precedent in the rationing of health care. If this rationale is accepted, it is only a quantitative step to apply the principle to anyone whose disease or distress is in any sense self-induced: cigarette smokers or heavy drinkers, those

who are too fat or too thin, who take no exercise or injure themselves playing sport, who work too hard or not hard enough, who don't wash their hands before eating. If that philosophy prevailed, it would certainly solve the problem of waiting lists in the NHS.

Marks[8] has argued compellingly that methadone prescribing should be much more widely available. On the evidence of American research[11 12] this would have profound benefits for individual and public health, lessen the drive towards street crime, and reduce demand and hence profit in the black market. In view of the established benefits of methadone maintenance one could even argue that it is unethical to withhold it. Should a doctor bear some responsibility if a harm (for example a fatal overdose, or infection with the HIV virus) arises in part as a consequence of an act of omission in refusing legal opiates to an addict requesting help? Of course, the prescriber's first duty is to avoid making matters worse by creating dependency or feeding the black market, but there are straightforward ways of avoiding these mistakes which could be addressed through postgraduate education.

Some doctors argue that to supply addicts with drugs is to collude with an undesirable activity and subvert motivation to quit. I suggest that not to do so when the time is right is to take an unrealistic attitude towards drug dependency, and, in effect, to collude with the organised criminals who are undermining our culture. It is true that a prescription is only one of the many possible strategies available for helping addicts, and often would be quite inappropriate. But for many, perhaps the majority, there is an addiction "career"[13] which has to run its course. For the duration of this career, there is almost nothing a heroin or crack addict will not do to obtain drugs. Being turned away by a doctor will certainly not deter them, so they will continue to pay large sums to a dealer for a grubby and adulterated supply. Apart from burglary, car-crime and prostitution, the easiest way to raise this money is by selling drugs for profit to friends and acquaintances. The heroin black market is thus a vast pyramid-selling operation, with all the pressure techniques that this implies. The medical profession has the power to undermine this monster without any change in the law.

If the logic of prescribing methadone is accepted, the possibility of prescribing other drugs to addicts who are not interested in methadone, for example heroin and cocaine, should be considered. The disastrous effects of excessive or misguided prescribing are evident from the experiences of the sixties and seventies, but with adequate standards of practice and perhaps with the active cooperation of the local police, these difficulties can be overcome.[14] Having such options on offer will bring more chaotic people into contact with doctors and other health workers. Rapport can then be built up which will make advice about healthier lifestyles more acceptable.

The time for inertia, disinterest, or temperance-style moralising is past because, like it or not, we are all at risk from "the drug problem". Far from making the world a safer and happier place, the current legal and professional approach to non-medical drug use is contributing to a crisis which threatens the stability of our society. It is also inhumane and a denial of personal autonomy and responsibility.

I am not qualified to develop the ethical and moral arguments which should be fuelling and enriching a debate that could lead to a more rational response, but I would like to challenge readers of this journal who are equipped to do so to make their voices heard.

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References

1 Ashton M. From cradle to rave – the rise of youth drug use. *Druglink* 1993; **8:** 12.
2 Institute for the study of drug dependence (ISDD). Table 4: New drug addicts notified to the Home Office during the year by age and sex. In: *National audit of drug misuse statistics; drug misuse in Great Britain*. London: ISDD, 1991.
3 Abadinsky H. Heroin maintenance and drug legalisation. In: Abadinsky H. *Drug use: an introduction*. Chicago: Nelson-Hall, 1989.
4 Farrell M, Strang J. The lure of masterstrokes: drug legalisation. *British Journal of Addiction* 1990; **85:** 5–7.
5 Saunders JB. The great legalisation debate. *Drug and Alcohol Review* 1990; **9:** 3–5.
6 Stevenson R. The case for legalising drugs. *Economic Affairs* 1991; **Feb:** 14–17.
7 Rathod N. Substitution is not a solution. *Druglink* 1987; **2:** 16.
8 Marks J. State-rationed drugs. *Druglink* 1987; **2:** 14.
9 Robson PJ. *Forbidden drugs*. Oxford: Oxford University Press, 1994.
10 Institute for the study of drug dependence (ISDD). Table 12: Average purities of police drug seizures analysed by the Forensic Science Service; Table 13: Typical retail prices of drugs on the illicit market, by drug, London and Glasgow. In: *National audit of drug misuse statistics: drug misuse in Great Britain*. London: ISDD, 1991.
11 Ball JC, Lange WR, Myers CP, Friedman SR. Reducing the risk of AIDS through methadone maintenance treatment. *Journal of Health and Social Behaviour* 1988; **29:** 214–226.
12 Hser Y-I, Anglin MD, Chou C–P. Evaluation of drug abuse treatment – a repeated measures design assessing methadone maintenance. *Evaluation Review* 1988; **12:** 547–570.
13 Vaillant GE. What can long-term follow-up teach us about relapse and prevention of relapse in addiction? *British Journal of Addiction* 1988; **83:** 1147–1157.
14 Self W. Drug dealer by appointment to HM Government. *The Observer* 1992 Sept 15: 49.