in which the keynote is the open door. On the other, because of the custodial function imposed on it for the care of patients under compulsory orders, it is expected to offer security. In this respect it fails largely because it makes no real attempt to succeed. The mental hospital without bars is one of today's major paradoxes. As a result of this failure in security patients frequently abscond. Rollin showed that, in the two years 1961 and 1962, 66 men on hospital orders, including 10 with restrictions on discharge (sections 65 and 72), absconded from his hospital, which admittedly accepts more than its share of patients on orders. All told, the men in this group absconded 188 times. No fewer than 30 of them (45%) were discharged by "operation of the law," or, having been rearrested and convicted during their absconcence, were sentenced to imprisonment or admitted to Broadmoor. The loopholes in the law make escape easy, and it is absurd to commit patients guilty of dangerous crimes to conventional, non-security hospitals.

There are other factors which embarrass the working of the Mental Health Act, not the least of which is the belief in some circles that mental illness and criminal behaviour are mutually exclusive. But that a man can be both insane and a rogue is borne out by the work, for example, of J. S. Bearcroft and Mary D. Donovan.[5] Of 146 male offenders examined by Bearcroft in 1963 63 (43%) had previously been sentenced to prison and 20 had had over ten previous convictions. Of the same cohort 113 (77%) had been treated in mental hospitals, 25 (17%) of them having been admitted more than three times. These figures accord with those of other workers, and it is a fair assumption that a high proportion of these offender-patients are incurable in psychiatric terms and incorrigible in legal terms. They are part of an army of chronic psychotics who are shunted between penal institutions and mental hospitals, clogging the first and impeding the second.

The anomalies in the working of the Mental Health Act, 1959, must be ironed out if the vastly important Act itself is not to fall into disrepute. It seems inevitable that security hospitals in addition to the special hospitals already in existence will have to be built. To these, after consultation between judges and doctors, both the incurable-incorrigible group of people could be sent and those with restrictions on discharge. Consultation between judges and doctors on the disposal of these people is at present slight, as our Legal Correspondent points out in an article at page 373 of the *B.M.J.* this week. It surely ought to be increased. With the kind of safety devices built into the present system of discharge from, say, Broadmoor there would be far fewer tragedies of the sort that Lord Parker referred to.

[1] *The Times*, 25 January 1966.
[2] Rollin, H. R., *Brit. med. J.*, 1963, 1, 786.
[3] Morris, T., and Blom-Cooper, L., *A Calendar of Murder*, 1964. London.
[4] Rollin, H. R., *Proc. roy. Soc. Med.*, 1966, **59**, 701.
[5] Bearcroft, J. S., and Donovan, M. D., *Brit. med. J.*, 1965, 2, 1519.

Special Experience and Service

For the second time in five years general practitioners are to be asked their opinion of a scheme for the distribution of extra payments to selected doctors. In 1962[1] they rejected a plan for the distribution of the half a million pounds a year offered by the Royal Commission.[2] During discussions on the "Charter" in 1965 the Government asked for another scheme to be prepared,[3] and last year the Review Body increased the sum to be distributed to over two million pounds a year.[4] This money was for payments for special experience and service to general practice. If the profession did not accept these payments the Review Body recommended that the money should not be distributed in other ways.[5] A working party set up by the General Medical Services Committee was given the task of preparing a method of selection of doctors for these allowances, and its report appears in the *Supplement* at page 39. The Conference of Local Medical Committees and the B.M.A. Annual Representative Meeting will debate the report in June and July this year, but the Conference is pledged to hold a plebiscite of all general practitioners before any scheme for the distribution of payments for special experience and service can be put into practice.

Two questions must be answered. Firstly, do family doctors want "merit awards"? Secondly, if they do, is this the right scheme? When the N.H.S. was introduced many doctors believed that capitation payments should be the only method of payment: the better the doctor, the more patients he would attract. In the present situation this is seldom true. Very few doctors would welcome more patients; and for those who would—some rural practitioners, for example—there are no patients to attract. But some doctors have greater ability than others, and some work harder than others. This should not go unrecognized. Accountants, architects, solicitors, and most professional men have this in common—the better they are at their job, the higher their fees and the greater their income. Even in vocational professions such as the church and nursing ability can be rewarded by promotion. But there is no promotion in general practice, and, it is argued, young men of high ability will not be attracted into a branch of the profession where harder work and higher standards have no extra reward other than personal satisfaction. If this is true—and few would now dispute it—then merit awards could be one answer, and doctors might be prepared to accept them if they were convinced that the system was trustworthy and that it picked the right men.

The debate in the last few years has provoked strong feelings because there is widespread disagreement as to the characteristics of the "better" doctor. Many doctors see merit awards as a means of encouraging the development of general practice in a particular direction. Others deplore attempts to impose a pattern by financial incentives. They believe in single-handed or two-man practices, where the doctor knows his patients and they trust him. They practise from their own homes, they take little part in local or national medical activities, and they keep up to date by reading the

[1] *Brit. med. J., Suppl.*, 1962, **1**, 272.
[2] *Royal Commission on Doctors' and Dentists' Remuneration 1957-60*, 1960, Cmnd. 939. H.M.S.O. (See *Brit. med. J., Suppl.*, 1960, **1**, 63.)
[3] *Brit. med. J., Suppl.*, 1965, **2**, 153.
[4] *Review Body on Doctors' and Dentists' Remuneration, Seventh Report*, Cmnd. 2992, 1966. H.M.S.O.
[5] Ibid., para. 201

journals. Such men will reject any scheme which suggests that they are second-rate doctors.

The working party has devised an ingenious answer to this problem. It starts with the premise that the awards are not merit awards at all, but are awards for service to general practice. The quality of care given to patients will not be a criterion. The report states that " advancement allowances would not be intended to convey and must not be interpreted as conveying or even implying any judgement as to the professional merit or distinction of recipients in relation to the actual quality of the care which they may give to the patients." The report puts forward nine criteria which should be used in the selection of doctors for awards—preparation for practice, postgraduate study, practice organization, teaching, research, " original ideas," administrative service, work for the community, and " other." The working party explains that it does not expect proficiency in every sphere and recognizes that in some circumstances, such as single-handed practice, special conditions may apply. Doctors must now decide if these criteria conform with their concept of the best general practitioner of the future—for if accepted this scheme will be the mould from which the new generation will be cast.

Measures Against Drug Addiction

The Government will introduce a Bill this session to give effect to the Brain Committee's recommendations. Among other things it will empower the Home Secretary to specify a new category of dangerous drugs and provide for the licensing of doctors to prescribe them to addicts. It will not affect the right of doctors to prescribe any drug for the treatment of organic disease. The Bill will also require doctors to notify cases of addiction.

These measures are being taken to meet the increasing addiction to dangerous drugs in Britain and have already been endorsed by the B.M.A. Representative Body.[1] In outlining the forthcoming Bill's provisions Miss Alice Bacon, Minister of State at the Home Office,[2] stated there were 62 known heroin addicts in 1958, 132 in 1961, 342 in 1964, and 521 in 1965. The data for 1966 were incomplete but for the first nine months amounted to 670 cases, which included 279 new cases. The pattern of heroin addiction has changed dramatically over recent years.[3-5] Cases in which the source of addiction was therapeutic outnumbered non-therapeutic addicts until 1964, and it is clear that the recent increase in prevalence is almost entirely due to addiction of non-therapeutic origin. In 1959 addicts under the age of 35 were rare, while now they account for more than half the total cases. Abuse of heroin by adolescents was virtually unknown before 1959, yet in 1965 there were over 100 known addicts aged under 20. I. Pierce James[6] has shown that the mortality among heroin addicts in the United Kingdom addicted from illicit sources is 22 times the expected rate in an equivalent normal population. Seldom can a memorandum have become outdated faster than the first Brain Report.[7] The second report,[8] published in 1965, was forced to reverse most of the 1961 recommendations: events had moved on with astonishing rapidity. Now the Vera Institute of New York is quoted[9] as forecasting 11,000 heroin addicts in Great Britain in 1972.

One important decision that the Government has made is that outpatient clinics shall be set up to offer maintenance prescribing of addictive drugs by specially appointed staff. Every effort will be made to persuade the addict to proceed from maintenance to withdrawal. J. Merry[10] has recently described his experience with a clinic like those envisaged. And interesting results have recently been reported by V. P. Dole and his colleagues[11] on methadone substitution. They find that a single daily dose of this drug by mouth blocks the euphoric effects (and withdrawal symptoms) of heroin, and preliminary results on the treatment of 128 chronic heroin users are most encouraging. Several important questions remain to be answered. Who is to staff the clinics? Is money to be forthcoming for the large-scale testing of blood and urine which may be needed if dosage is to be properly adjusted? Are addicts of eccentric appearance easily accepted in the registries or waiting-rooms of outpatient departments, or will new building be necessary? If these clinics are to offer energetic therapy rather than act merely as centres for handing out drugs they will be expensive to run, yet one of the reasons why the American Narcotic Clinics of the 1920s fell into disrepute seems to have been that they largely abdicated any true therapeutic role.[12] If the clinics are to keep the black market out of business the staff will have to cultivate much skill in gaining and holding the confidence of their patients: M. E. Chaftez[13] has shown that with alcoholic outpatients a clinic properly designed to meet their immediate needs greatly improved the reattendance rates. Essential to the working of these clinics will be the proposed notification of addicts. The details of the scheme have yet to be worked out, but the arguments for an effective system are now overwhelming.

The Minister of Health favours small specialized inpatient units which would take not more than 12 heroin addicts at one time,[14] and A. Kaldegg[15] has described a unit of this type which is being run at Cane Hill Hospital. M. M. Glatt[16] believes, on the basis of considerable experience, that addicts and alcoholics can be treated in the same wards, while other authorities would fear that heroin may spread by " infection." The question of compulsory detention for treatment has also been debated,[17] but the Government is not at present accepting this particular recommendation of the Brain Committee.

The importance of rehabilitation is stressed in the Government's current proposals. There is talk of hostels, with a glance across the Atlantic,[18] but though there have now been some years of experience in Britain with hostels for the rehabilitation of alcoholics[19] no one is yet sure whether putting

1 *Brit. med. J. Suppl.*, 1966, **2**, 48.
2 *Hansard*, 30 January 1967, col. 167; see *Brit. med. J.*, 1967, **1**, 311.
3 Bewley, T., *Lancet*, 1965, **1**, 808.
4 —— *Brit. med. J.*, 1965, **2**, 1284.
5 —— *Bulletin on Narcotics*, 1966, **18**, 1.
6 James, I. P., quoted by Bewley, T., *Bulletin on Narcotics*, 1966.
7 *Drug Addiction: Report of the Interdepartmental Committee*, 1961. H.M.S.O.
8 *Drug Addiction: Second Report of the Interdepartmental Committee*, 1965. H.M.S.O.
9 *The Times*, 22 January 1967.
10 Merry, J., *Lancet*, 1967, **1**, 205.
11 Dole, V. P., Nyswander, M. E., and Kreek, M. J., *Arch. intern. Med.*, 1966, **118**, 304.
12 Narcotics Addictions: Official Actions of the American Medical Association. A.M.A. 1963.
13 Chafetz, M. E., *Quart. J. Stud. Alcohol*, 1961, **22**, 325.
14 *Hansard*, 30 January 1967, col. 138.
15 Kaldegg, A., *New Society*, 2 February 1967, p. 154.
16 Glatt, M. M., *Lancet*, 1965, **2**, 171.
17 —— *Bulletin on Narcotics*, 1966, **18**, 29.
18 Volkman, R., and Cressey, D. R., *Amer. J. Sociol.*, 1963, **69**, 129.
19 *The First Five Years*. West London Mission Alcoholic Rehabilitation Centre. 1965. London.
20 *The Times*, 23 January 1967.
21 Ministry of Health Hospital Memorandum, No. 43. 1962.
22 *Brit. med. J.*, 1966, **1**, 1493.
23 Chein, I., Gerard, D. L., Lee, R. S., and Rosenfeld, E. *Narcotics, Delinquency and Social Policy: the Road to H.* 1964. London.