*For Debate . . .***Prescribing psychoactive drugs to addicts**

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Prescribing drugs of addiction to patients who are dependent on them is still acceptable medical practice in Britain. Such prescribing should always be done responsibly and in a controlled way. Professional disrepute may occur if a doctor, under the guise of treating patients, provides addicts with large amounts of addictive drugs in return for a fee. Addicts label this type of practitioner as "easy writer" or "Doctor Scripts." The public and the medical profession become aware of such doctors when they appear before the General Medical Council. Some of these doctors are themselves either old, ill, or dependent on drugs or alcohol. The new health committee of the General Medical Council may in future be able to help such doctors before their behaviour gives rise to concern.

Increasing numbers of addicts (who may be dissatisfied with NHS clinics and want more drugs prescribed or who would prefer injectable drugs) make the rounds of doctors until they find a naive or complaisant practitioner to prescribe for them. Both general and private practitioners may be approached. When a patient asks a doctor whether he will prescribe drugs of addiction privately, the doctor should consider the full implications of such a course of action. A patient who sees a doctor as a private patient once a week and who is given a prescription for five ampoules of methadone daily (50 mg) might pay £25 each week for his consultation fee. If the patient is unemployed and supported by social security some of the prescribed drugs might be sold on the black market (an ampoule of methadone can be sold for £5 and five ampoules out of the 35 prescribed each week would provide £25).

A doctor in private practice who prescribes for 20 such addicts could earn £500 a week or over £25 000 a year from this group alone. The black market price for the ampoules of methadone (if 20 addicts were prescribed five ampoules a day each) would be £500 a day or over £180 000 a year. If only one-seventh of this were sold it would still be over £25 000 a year. 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. We need to ask two questions: "Is it ever wise to prescribe psychoactive drugs privately to an addict in return for a fee?" and "What further safeguards are necessary to control improper prescribing?" The medical profession should consider whether there is any place for private treatment of addicts where a fee is contingent on a prescription. Perhaps such prescribing should be confined to licensed practitioners only. There may be no other way to say "Goodbye, Doctor Scripts."

At a recent meeting of consultants in charge of London drug dependence clinics, the following guidelines were commended as a basis for further discussions of this topic.

Guidelines

(1) All doctors should be aware that it is possible to become dependent on (addicted to) drugs of various types, including both those controlled under the Misuse of Drugs Act and other drugs such as barbiturates.

(2) All doctors should recognise when they prescribe such drugs that dependence is one of the known ill effects, and they would be expected to keep this in mind in the way they prescribe.

(3) All doctors should know that when someone is dependent on, and addicted to, a drug he may go to considerable lengths to obtain that drug; and that this may include endeavouring to obtain it from a medical practitioner. Because of this there are no circumstances in which a drug of this type can be prescribed to somebody without certain elementary checks and precautions to minimise the possibility that the prescribing of the drug is merely feeding an addiction.

(4) When a patient is known to a doctor and being treated for a specific complaint it is merely necessary to keep in mind the possibility that too much of the drug may eventually be prescribed.

(5) When a patient is not known to a doctor and when it is not known what drugs have been prescribed previously, considerably greater precautions are required.

(6) When a patient is not known to a doctor and specifically asks to have a drug which is known to be addictive prescribed, an even greater degree of caution is required.

(7) When a patient consults a doctor as a private patient seeking psychoactive drugs the highest degree of caution is required. Receiving a fee from a patient should not lead to any less careful control of prescribing of psychoactive drugs (because of the greater need to please the patient) than would be the case if he were not a private patient.

(8) For these reasons when a patient who is not known to a doctor asks for a prescription for a controlled drug (or a drug such as a barbiturate) the very minimum that would be expected of any doctor would be that he should: (a) examine the patient, make a diagnosis, and decide whether he himself thinks such a prescription would be appropriate; (b) find out who had been previously treating this patient to know what previous treatment he had received; (c) find out what previous drugs the patient had had; and (d) in an emergency prescribe no more than one day's normal supply of the drug, which would give him time to find out from the patients' previous practitioners what treatment had been received.

(9) If a doctor is threatened by somebody who demands drugs of addiction it would be improper medical practice to give the drug to the patient for this reason rather than refuse to prescribe (and if necessary call the police). In extreme circumstances there might be such exceptional threats to a doctor

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that he has no alternative to prescribing or dispensing drugs of addiction, but in such a case he should immediately notify the police after the threatening and violent client has left.

(10) PRESCRIBING OPIATES FOR ADDICTS AS TREATMENT

Maintenance treatment

Normally maintenance treatment will be provided by a doctor who is licensed to prescribe heroin and cocaine and one who is exempted from the handwriting requirements of the Misuse of Drugs Act. The very least that would be required of any doctor proposing to prescribe opiates to an addict as part of treatment would be the following:

(i) A diagnosis of physical dependence should have been made.

(ii) This should have been confirmed by an appropriate history and physical examination of the patient. It would be desirable also to have arranged for urinary analysis to confirm what drugs were being used.

(iii) Extra care should be taken in the case of a patient who is not already known to the doctor, particularly one who is being treated as a temporary resident or privately.

(iv) No treatment, apart from emergency treatment, should be given without first finding out what previous or current treatment the patient has had or is having from other doctors.

(v) If a patient attends a doctor privately for such treatment the doctor must ensure that the patient is coming for treatment and not solely to obtain drugs on prescription in return for a consultation fee. The questions to be asked in such a case are:

- (a) Has the doctor special expertise in the treatment of drug dependence? (b) Has he proper facilities (access to hospital facilities such as urine analysis)? (c) Is he providing treatment other than a prescription for a controlled drug? (d) Is he prescribing drugs in such a way that there is an inducement to addicts to attend him privately (by prescribing more "liberally"—for instance, giving larger amounts of drugs or drugs that are more attractive to addicts (such as heroin or

injectable drugs) when these are not available except from a private practitioner)? (e) Does he prescribe drugs such as amphetamines for which there is little medical indication for patients who want them for other reasons?

Emergency treatment of opiate withdrawal symptoms

Treatment of physical dependence on opiates is best carried out by a medical practitioner with special experience (generally one licensed to prescribe for addicts). Should emergency treatment be required this would normally best be done by referral to the accident and emergency department of a general hospital. If in unusual circumstances—for example, in the depths of the country—it were not possible to do this, it would be not unreasonable to prescribe to treat withdrawal symptoms, provided that there was clear evidence that they were present and that not more than one day's supply of the drug was given until inquiries could be made about appropriate treatment for the person concerned. (Normally methadone would be used.) The name of the patient should be notified to the drugs branch of the Home Office. The greatest care would be expected of any practitioner who was faced with a patient who stated that he was an addict and was having withdrawal symptoms (particularly if he presented as a private patient). Most patients who present themselves to doctors in this way are known to be addicts who are seeking further drugs because of their addiction, and it is exceptional that genuine withdrawal symptoms require instant treatment.

(11) TREATMENT OF BARBITURATE WITHDRAWAL SYMPTOMS

The barbiturate withdrawal syndrome is best treated in hospital with barbiturates alone and cannot satisfactorily be treated by giving a prescription for barbiturates to a physically dependent person.

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What is rugby player's ear?

Both boxers and rugby players may suffer injuries to their ears, the cartilage becoming deformed by trauma, especially in the rugby scrum—with the development of a type of miniature "cauliflower ear" and the appearance of a lump or nodule not unlike a tophus on the upper edge of the ear (a similar appearance may sometimes be seen with no history of trauma). This may simulate a tophus, but it transilluminates normally, whereas a tophus shows a dark spot on transillumination. The lump is of the same colour as the rest of the ear, whereas tophi usually appear yellow under the skin.¹ Rheumatoid nodules are seen occasionally in the same area from constant pressure of the ear on the pillow at night when the opposite shoulder is too painful to bear the body weight.

¹ Dudley Hart F, ed. *French's index of differential diagnosis*. 11th edn. Bristol: John Wright, 1979:464.

A patient has different blood pressure measurements in each arm: the right is 150/95 and the left 130/80. The right arm is fat and muscular, while the left is thinner and the forearm is affected by an extensive radioulnar synostosis, with consequential underdevelopment of that limb. Which is the "correct" reading?

First, some questions: were the measurements made simultaneously? If so, did the difference persist when observers and sphygmomanometers were switched from one arm to the other? If measurements were not simultaneous, minute-to-minute variation of blood

pressure is a possible explanation for the difference. But if the difference is consistent and the measurements were simultaneous there are two possible explanations. Recordings made using a sphygmomanometer cuff of conventional size tend to overestimate pressure in fat or muscular arms and to underestimate in thin arms or the arms of children. Both errors might have been combined in this patient so that the "correct" reading would be somewhere between the two given. As a test, the measurements could be repeated using a long broad cuff on the right arm and a smaller or paediatric cuff on the left arm. If the difference diminishes or disappears it is probably an artefact of technique. Occlusive arterial disease on the left is much less likely.

Pickering GW. *High blood pressure*, 2nd edn. London: Churchill, 1968.

Will vitamin B₆, which is sometimes useful in treating premenstrual tension, harm the fetus if a patient continues taking it into early pregnancy?

The role of vitamin B₆ in pregnancy is not clear. There have been suggestions of deficiency being a cause of convulsive disorders in infants,¹ and that therefore vitamin B₆ supplements should be given in pregnancy. It seems unlikely that normal therapeutic doses of the vitamin taken in early pregnancy would have a deleterious effect on embryonic and fetal development.

¹ Cleary RE, Lumeng L, Li T-K. Maternal and fetal plasma levels of pyridoxal phosphate at term: adequacy of vitamin B₆ supplementation during pregnancy. *Am J Obstet Gynecol* 1975;121:25-8.