

Responding flexibly but not gullibly to drug addiction

Recent debate on treating opiate dependence has focused on the opposites of either all patients being given maintenance treatment or all of them being detoxified. Most of those working with drug takers would, however, advocate flexibility in tailoring treatments to individuals. But what treatments should be available and, crucially, when should the more unusual and controversial treatments be used? And who should choose the treatment—the drug taker or the doctor?

The discussion often hinges around reducing harm. A total ban on prescribing is clearly not the answer, but nor may an ever ready provision of "state rationed supplies" be the best way of reducing harm.¹ This is a policy which if widely and indiscriminately adopted is an insult to the potential within many drug takers to reduce their drug taking. A two year follow up study of a cohort turned away from treatment found that 61% of drug users had reduced their dose and 42% had reduced the frequency of injecting, while only 7% had increased their dose and 4% their frequency.² Elsewhere, Gossop *et al* found half of opiate addicts to be drug free six months after inpatient treatment, and several of those who continued to take drugs took them in a less intense and damaging way.³ Where would they be now if maintenance treatment had been available on demand?

Individual patients need individual treatments, and a central feature of working with drug addicts is coaxing and cajoling them through change. Edwards has described this basic work as "largely concerned with nudging and supporting the movement along natural pathways of recovery."⁴ Treatment must not be seen as synonymous with prescribing. Doctors can do much for general health care apart from prescribing,^{5,6} and prescribing drugs to addicts does not necessarily solve their problems. Many drug users continue to use other drugs over and above their prescribed supplies.⁷ Some may swap their supplies; some may sell them or give them to friends; and some may take them in ways other than directed—for example, taking several days' supply at once, or crushing tablets and injecting them.

We must be clear what we are trying to achieve with each opiate addict to whom we prescribe drugs. Perhaps this month we are helping him to sever his links with drug using acquaintances and the black market. The next month we may help him to stop injecting and the following month to reduce his dose and to stop. In all these examples treatment is still towards a goal, albeit an intermediate goal.² This tailoring of treatment to the individual has been practised for several years by many drug dependence treatment units. Treatment contracts are negotiated with each patient.^{8,9} Flexibility of response is not a new concept to specialists, but its widespread and sympathetic application is now a matter of urgency.

Treating drug addicts is not, however, solely the responsibility of experts in specialised clinics. Many general practitioners are now treating addicts.¹⁰ Unfortunately, debate on maintenance treatment is likely to confuse the generalist who has cautiously begun to embark on providing more straightforward elements of service; and the passionate preaching of the zealot who advocates maintenance treatment for all is likely to drive such non-specialists back into the intransigence that was so evident in the 1970s. The Department of Health and Social Security *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* encourage

the non-specialist to provide basic health care and straightforward prescribing packages to the drug taker, including rapid detoxification or slower withdrawal over many months.⁵

These guidelines are being re examined. Any new advice should distinguish between the more straightforward elements of treatment that can be taken on by all doctors and the more complicated elements—such as prescribing injectable drugs or maintenance supplies—that should be tackled only by specialists with their back up. This is surely the only way in which the range of responses will become wider and more flexible while the contribution from the generalist is retained and increased.

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Postphlebotic syndrome after fractures of the leg

Fractures are invariably associated with damage to the adjacent veins so not surprisingly deep venous thrombosis is a common complication. Indeed, phlebography has shown that this occurs in over two fifths of patients with a fractured femur. Thromboses have two major sequelae: the acute, dramatic, and sometimes fatal pulmonary embolus and the insidious, protracted problem of the postphlebotic leg. Fatal pulmonary embolus is uncommon, occurring in only 5% of even elderly patients with a fractured neck of femur. Conversely the problem of the postphlebotic leg has been underestimated by the results of short term follow up studies.¹

After thrombosis the veins eventually recanalise in over four fifths of patients but this process may take between nine months and six years.² The recanalised vein has no valves and is therefore incompetent, so that the calf muscle pump is inefficient. Hence the patient develops aching legs, swollen ankles, and the brawny skin pigmentation of lipodermatosclerosis; eventually the skin may ulcerate. Once the diagnosis

is made, adequate below knee support stockings may improve the symptoms and reduce the late sequelae. Some patients may benefit from ligation of the calf perforating veins, but there is no cure for deep venous incompetence; venous valve grafts are being evaluated but are not of proved benefit.

Valves occur most frequently in the popliteal and calf veins, and hence thrombosis in the lower leg and subsequent recanalisation are more likely to lead to deep venous incompetence than is thrombosis in the proximal limb—as witness the fact that tibial fractures lead more frequently to post-phlebotic legs than do femoral fractures.³ Similarly major thrombosis of the iliac vein is no more likely to lead to postphlebotic legs than are the smaller distal thromboses.⁴

Aitken and his colleagues recently showed how common the postphlebotic leg was in patients with a previous leg fracture by studying them many years later.⁵ No fewer than half of 60 patients studied at least 15 years after the fracture had the symptoms and signs of the postphlebotic leg; conversely only 4% had symptoms and 24% signs in the unaffected leg. Given that the syndrome may take a considerable time to develop it is clearly much more frequent than had been thought; nor is the problem confined to the elderly: young patients are also vulnerable. Although those aged under 25 have a lower incidence of thrombosis, thereafter the frequency is unrelated to age.³ Hence doctors should consider a more aggressive approach to using anticoagulants in young patients with fractures of the legs. This was suggested in the early 1960s⁶ but has rarely been implemented, presumably owing to the low incidence of pulmonary emboli and the fear of bleeding problems. Prophylactic subcutaneous heparin has been less effective in orthopaedic procedures than in general surgery,⁷ but heparin together with dihydroergotamine, or adjusted doses of heparin, dextran, and warfarin have given more encouraging results.

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Contraceptive services for ethnic minorities

Problems arise with contraceptive services for ethnic minorities because they are planned and provided by professionals from the ethnic majority, and the problems are caused not by the peculiarities of the ethnic minority but by the fact that the services are crossing cultures.

In an ideal world people would receive advice on con-

traception from a trained person of the same sex and racial background in a language they understood in an environment they found acceptable and non-threatening. Unfortunately much contraceptive advice for members of ethnic minorities in Britain is provided by doctors of a different culture from that of the patients. The doctors often do not speak the same language¹ and may have stereotyped views about the patients' cultures.²⁻⁸ White doctors may also have little insight into the effects of racism on patients (and colleagues) from ethnic minorities. How can things be improved?

Authorities organising contraceptive services need to identify the communities that they are providing for and their special needs. They should know who makes the decisions on contraception and how they may best be contacted. The factors that influence the decisions on contraception are many and varied. Religious belief is often not as important as many think,^{5,6} though it may dominate decisions for some people. It may also have effects in indirect and unexpected ways—for example, by emphasising the importance of sperm or attaching taboos to menstruation. Usually more important than religion, however, are people's experience and future plans, the influence of peer groups, economic factors, and media publicity.^{5,6} Publicity about services must be in a form accessible to communities, and the written word—albeit in the right language—may often not be adequate.

Authorities must consider who provides the services. One aim should be to offer wide choices of advisers in terms of sex, race, and class, but staff should also be offered training in racism awareness, cross cultural consulting, and health and religious beliefs. Despite their widespread use, interpreters are often not helpful except in translating the doctor's instructions. Much better are patients' advocates.⁷ These are trained members of ethnic minorities who both interpret the patients' needs and beliefs and provide an insight into the current beliefs of that community. They also interpret the needs of the medical community to the patient and are available for advice on health education and training of staff. All areas with large communities of ethnic minorities should consider employing advocates.

Finally, there are two points worth making. Firstly, improving contraceptive services for ethnic minorities will also improve services for the majority by improving skills in eliciting patients' beliefs and fears and in communicating and by leading to more flexible services. Secondly, it is no longer good enough for investigators to peer in on ethnic communities from the outside and make decisions about them. Information should come from workers who originate from the ethnic communities, so that decisions are made from within the community.⁸

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