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Editorials

DRUGS, DEATHS AND DILEMMAS

> In a consumer society there are inevitably two kinds of slaves; the prisoners of addiction and the prisoners of envy.
>
> *Ivan Illich, Tools for Conviviality 1973*

Five decades ago the World Health Organisation, in an upbeat and optimistic postwar profession of intent, defined health as a 'sense of complete physical, mental and social well-being and not merely the absence of disease and infirmity'.[1] Over the last decade the spiralling, ever-changing and constantly diversifying drug culture has taken its toll of morbidity and mortality, particularly in the younger age groups, and has certainly militated against the fulfilment of this Utopian vision of society.

Consideration of the statistical information that is available shows that the broad canvas of the incidence of drug abuse alerts all to a depressing situation, which over the last decade has shown little sign of change for the better. The International Narcotics Control Strategy Report of the US State Department for April 1994 states[2] 'UK authorities believe heroin abuse is the biggest drug problem. They acknowledge that while the anticipated crack cocaine epidemic has not occurred, cocaine use is increasing. Of all European nations, the UK has the highest demand for LSD. Each country in the world has its own drug problems and these differ markedly. Here only those in the UK are discussed and hopefully this may interest readers in other countries.

A survey which sampled prospectively 14 and 15 year olds in three Wolverhampton schools since 1969 reports that by 1994 the proportion who knew someone taking drugs had risen from 15 to 65 per cent and those offered drugs from 5 to 45 per cent.[3]

Drug dependence is undoubtedly a serious health problem fraught with the dangers of huge direct health expenditure and a major toll of psychiatric and physical illness, but also carries a secondary burden of massive costs in terms of crime, loss of earnings and productivity, fundamental damage and disruption to the social order, and death—often at a premature age. It is therefore not surprising that reduction in the extent of drug dependence has become a major national target of the health and social services, with priority given to it in the allocation of resources and personnel. The main, some would say dogmatic, thrust of governmental health service resources has been into education—through the media and in schools. Around £32 million were spent by central government in high-profile campaigns against drug abuse in the early 1980s; in 1993 this sum had increased tenfold. Yet the beneficial effects of these initiatives are questionable. In the opinion of Mr M. Ashton of the Institute for the Study of Drug Dependence, there is strong evidence that British drug education educates, and this may well be justification enough. We can also hope that it prevents drug use and harm—but at the moment, that remains an article of faith.

Most of the drugs misused in this country are imported. For some (heroin and cocaine) it is generally accepted that all production takes place outside the UK; although some cannabis is grown illegally in the UK, nearly all its illicit use

has been of imported material. The situation with amphetamine and other synthetic drugs is more uncertain; until recently it was believed by the National Drugs Intelligence Unit, now the Drugs Division of the National Criminal Intelligence Service (NCIS), that most amphetamines are UK produced. However, information from the profiling programme which is run jointly by the NCIS and the Drug Intelligence Laboratory suggests that the position has now changed. It is estimated that by late 1993 nearly all illicit amphetamine seized by the police had been imported. Other synthetic drugs (such as lysergide (LSD) and 3,4-methylenedioxyamphetamine ('ecstasy') are also thought to be largely of foreign production. There can therefore be little doubt that the surveillance by the police and Her Majesty's Customs and Excise (HMCE) officers has continued to stem some of the flow of illicit substances into the country.[4] However, as they would readily agree themselves, although their operations are recovering larger and more spectacular stashes of illicit substances, their efforts have to be compared to the Dutch boy's finger in the dyke in that only a small proportion of the drugs entering the country illegally are being confiscated (Table 1).

TABLE 1

Drugs seized by Customs and Excise and by the Police in 1983 and 1993 (kg).

	1983		1993	
	HMCE	*Police*	*HMCE*	*Police*
Cannabis	19,892	792	51,740	5,601
Heroin	2,159	203	5,371	1,208
Cocaine	nil	nil	6,792	226
Amphetamine	123	226	543	442

The resolve expressed unanimously by the main political parties in the UK to continue to strengthen these law enforcement agencies, by increasing their complement of personnel and equipment, is to be applauded. The international co-operation on both European and global levels in terms of mutual aid and the sharing of 'intelligence' continues to make inroads into this crime that respects no borders.

Legislation, regulation and control have also featured in this country's response to the problem, but there is dubiety in the minds of many as to how effective this has been. Indeed, a contrary viewpoint of relaxation has been often mooted: the well-rehearsed arguments for partial decriminalisation are rekindled with regularity in the public media and in the medical press.[5] In this context, the recent, but certainly effective, statutory measures to be introduced, was the confiscation by the courts of the assets of drug peddlers, and this has surely helped. Already over £515 million were appropriated by the courts from convicted drug traffickers. As Oscar Wilde put it, 'Nothing succeeds like excess'.

A system of compulsory registration of addicts by medical practitioners is also enshrined in statute, and yet it is common knowledge that doctors, whether in primary care or in hospital practice, *de facto* do not report the vast majority of the cases that come their way. It is felt that the time which such form-filling requires could be better spent in other useful activities. This widespread non-compliance with the letter of the law and with regulations is an open secret. Is it not time to suspend officially these regulations? Perhaps the money which the Home Office and the Scottish Office spend on such bureaucracy could be diverted into more cost-effective, more realistic and productive data collection.

In the same vein the collection of data about deaths from drug misuse has not been given the prominence that it deserves. It takes media-sensationalised deaths, such as that of Leah Betts after a birthday party exposure to 'ecstasy', to jolt us into awareness of this problem. The death toll from drugs in Strathclyde hovered around the hundred mark last year; arguments and counter-arguments have been exchanged by criminologists, politicians, social workers and journalists; plenty of energy has been invested in sound bytes, newspaper articles and TV with little direct illumination of the problem and unceasing deaths of yet more drug misusers.

With the exception of Scotland, there is the potential in Britain for holding public inquests into all such sudden unexpected deaths by HM Coroners, to whom these deaths are reported in the first instance and under whose aegis they are investigated by the police. In Scotland these deaths are reported to the Procurators Fiscal, but although there is a full inquiry into the circumstances that led to them, the conclusions of these investigations are to a great extent not in the public domain; only if the family of the bereaved takes up the invitation made by the fiscal some weeks after the death to visit his office and to discuss the details of the autopsy and the toxicological findings, will they then be given information directly related to the death. Because of the criminal 'hat' which the fiscal also wears, these invitations often go either completely unheeded or are availed of only partially. The 'nightmare' which the drug-related death has unleashed on the parents, workmates, acquaintances, carers and friends of the deceased remains and recurs. When it is felt that in the public interest the family deserve 'their day in court', the possibility does exist in Scotland of a discretionary 'Fatal Accident Inquiry' (FAI) which will be held in public. This expensive and cumbersome tool is rarely used and, when it is, a hidden agenda evolves in the minds of the legal representatives of the bereaved, seeking to find and to apportion blame, rather than a genuine attempt to find the lessons of that particular tragedy. Whatever benefits in terms of openness may be derived, both HM Coroner's courts and Sheriff courts (where FAIs are held) are perhaps not conducive to a proper and genuine attempt by health practitioners to understand and to seek to remedy this public health problem. These deaths do not usually occur in drug-novices or first-time experimenters but more frequently in a context of many years of substance misuse and contact with health and social services. These deaths should provide clues in auditing existing policies, and incentives to designing more effective strategies to reduce morbidity and mortality; at present, these opportunities are being sadly missed.

In this context a largely anecdotal phenomenon that is being observed throughout the larger cities in the UK is the increasing mortality from methadone.[6] Methadone was synthesised in 1938 and then referred to as Hoechst 10820 or Dolophine; (some erroneously attributed the choice of this name to Hitler's first name, rather than to the more appropriate Latin derivation, reflecting its analgesic properties). This chemical was rediscovered in 1964 by Vincent Dole and Marie Nyswander, and a therapeutic niche was found for it.[7] Nowadays this oral preparation is prescribed increasingly and more widely as part of a harm-reduction maintenance programme to stabilise intravenous opiate and opioid misusers. This led to a measurable improvement in the general health of

these patients, a reduction in drug-related and instigated crimes, decreased contacts with the criminal justice system, an amelioration of their social misfunctioning and a decrease in the spread of associated HIV infection. In spite of such eminently laudable and achievable goals, there is evidence that methadone is easily diverted into the 'black market' and the 'street reservoir' of illicit drugs and is thus not without its sociological problems. The toxicity and neuro-depressant effects of this drug are real and more so because of a variability in the development of tolerance. Sometimes a capricious loss of tolerance leads to inadvertent overdoses, and also it may be used in lethal cocktails with other drugs and alcohol. Methadone is increasingly found as the principal drug in post-mortem body fluids of deceased misusers.[7]

More recently the benzodiazepine (Temazepam) prescribed therapeutically, has also permeated extensively into the drug scene in Scotland and elsewhere; it has also been labelled as an 'addict-killer' particularly in the West of Scotland where there appears to be a preference for its misuse by the intravenous route.[8–10] In response—some would say belatedly—legislative amendments have been introduced to decrease its availability and these seem to have had some impact. Unfortunately the statistical information on the incidence and frequency of deaths caused by Temazepam are incomplete and inaccurate. The Registrar of Deaths in Scotland has responded to this with several measures aimed at the comprehensive collection and collating of information about drug-related deaths. A similar response may have to be put into action and co-ordinated by the Registrar General in the rest of UK to ensure completeness of these data.

Accurate data collection, an excellent aim in itself, should be only a prelude to a well-orchestrated attempt at reduction of such deaths. Every perinatal, and each post-perinatal and maternal death is now the subject of a local and of a national multi-disciplinary enquiry, and each intra-operative and post-operative death is carefully assessed. Is it not time for each drug-related death—two to three every week in Scotland alone, mostly under the age of 25 years—to be scrutinised similarly? Should not such investigations be carried out on a national scale and by an independent multi-disciplinary committee? Such confidential enquiries should receive and collate as much information as possible from general practitioners, social workers, community drug projects and voluntary agencies about the previous management and life history of the deceased. The data thus acquired could be scrutinised and assessed, changing trends and patterns identified, and lessons learnt passed on nationwide. In his monograph *The Affluent Society* John Kenneth Galbraith stated in 1958, 'Certainly not all of us who seek to interpret the effect of change are right—or even right in the diagnosis of change'.

If the drug-dependence mortality scene is changing, there should be a serious and spirited attempt to monitor it accurately and meticulously. Although not strictly within their 'common law' or statutory remit, HM Coroners and the Procurators Fiscal service, to whom all these deaths should be reported initially, are perhaps best placed to identify and flag these deaths, and bring them to the attention of the public health practitioners. As part of their death-related investigation full toxicological studies require to be made on post-mortem body fluids. These laboratory analyses are expensive and perhaps revenue may have to be channelled into such investigations from health sources. Potential breaches of patient and professional confidentiality and spectres of civil litigation, where care is found to be less than satisfactory, have been raised as objections against such

enquiries. These arguments are valid and need to be addressed, but they are not insurmountable. In the meantime deaths continue to occur and this is yet another 'occasion when an opportunity is let slip'.

The greatest recent advance in the study of addiction has been made in the understanding of the action of chemical mediators and the molecular pharmacology within the cerebral milieu of the major drugs misused.[11] This was made possible by the wider availability of more sophisticated neuro-imaging techniques. Manipulation of the brain's chemical micro-environment may alter the final common pathways through which physical and psychological drug dependence acts. When this is understood better, such manipulation may be able to relieve or even cure addicts.

The development of new medical services aimed specifically at drug misusers—a marginalised, unstable and vulnerable, yet demanding and often unappreciated, social group—has had to transcend budget-holding in general practice, and various health authorities and boards have gone out of their way to channel resources into such projects.[12] Within the National Health Service demands have gradually threatened to outstrip resources, and as the economic situation continues to give little leeway for complacency, apportioning resources is serious business. Yet another dilemma for managers is the provision of health care to drug misusers. If health care initiatives are to be funded they have to be shown to be effective; this truism holds just as true in the sphere of drug misuse and dependence. Valuable opportunities to monitor this problem effectively are being lost; perhaps through them the resolution of these dilemmas could be better achieved.

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I BELIEVE...

The article with this title (p 265) by Hugh Dudley, an emeritus professor of surgery, is the first of a series by doctors invited to contribute by the editors. The idea for the series came after reading again a book with this title published in

1940. In it were twenty-six articles by authors well-known at that time for their distinction in science and literature. They included W. H. Auden, Albert Einstein, E. M. Forster, J. B. S. Haldane, Julian Huxley, Bertrand Russell, Beatrice Webb, H. G. Wells and Rebecca West. These men and women had very different reactions to orthodox religious teaching, but there was within each of them some inner driving force which urged on their creative activity.

Doctors who have made a name for themselves either in the care of patients or in research laboratories, or both, have been people with energy above average. What has motivated them? What made them tick? We hope that this series will interest all our readers; also that it may be a spur that drives some of them on, especially the younger ones, to harder work and the longer hours necessary to provide kindly care and effective treatment of patients, and to add to the sum of medical knowledge and understanding.

DR WILFRED (BILL) SIRCUS AND *PROCEEDINGS*

Bill Sircus who has now retired from the editorship of *Proceedings* of the College has made an outstanding contribution, and the occasion causes one to ponder how he came to be suited for the role. Kind thoughts and words of tribute tend too often to emerge late in the day.

Bill came to Edinburgh in the middle 1950s, from Liverpool via Sheffield, and in both medical schools he had already earned respect. He joined Wilfrid Card in the joint medical/surgical gastrointestinal unit that had been established by Card with John Bruce in the Western General Hospital. This was the second of the units to be founded in Stanley Davidson's grand vision for the special branches of medicine that were emerging after World War II; it was, however, the first to acknowledge the essential interdisciplinary nature of modern medicine. It is strange how such an obvious truth has still not fully taken hold. Bill, throughout his active clinical life, fostered the development of teamwork with all the cognate disciplines that contribute to the best standards of clinical care and practice, and the group (and their successors) did outstanding work, at first on gastric physiology and peptic ulcer, but later on all aspects of gastrointestinal disease. I had experience of an interesting sequel. When I went to Sheffield in the early 1970s, there was some consternation and dismay because a certain Dr Sircus had refused to approve a senior registrarship in gastroenterology, unless a joint medical/surgical unit was established in the shortly to be completed new teaching hospital. However, Bill's evangelism and insistence did not fall on deaf ears and a very successful unit on the Edinburgh model was created forthwith.

I got to know Bill some 40 years ago for a quite different reason. He introduced me to what is now known as 'evidence based medicine'. Some of his pioneering work on gastric function was based on observations in dogs and for want of a proper locus for his studies, many of these were painstakingly and humanely done in an office-cum-laboratory which we shared in the old Department of Medicine.

Over the subsequent period, Bill maintained his original girth but grew enormously in stature. Despite his allegiance to a special branch of medicine, he was a first class general physician, highly regarded not only by his immediate hospital associates, who recall his ward rounds with great admiration, but also by the general practitioner community who made heavy demands on his opinion. From the outset, he understood the need to communicate fully and honestly with his patients who held him in the highest regard and equally importantly with his medical colleagues. Being highly articulate, he was an outstanding lecturer and lucid writer with much published original work to his credit. His skill as an endoscopist was enhanced by his skill as an artist and this he used in recording what he saw. He quickly developed a national and international reputation being recognised by high office in specialist associations. And so in Bill Sircus there were all the best attributes needed in British teaching hospital medicine, the sound physician, the careful scientist, the well read scholar, the good teacher but more than that, a man of integrity with a friendly and humorous personality who was at all times modest, kindly and courteous.

The *Proceedings of the Royal College of Physicians of Edinburgh* arose gradually