Medical Council on Alcohol Witness Seminar: 50 Years of the MCA and Alcohol Treatment

14 November 2017 at the British Medical Association

Moderator: Professor Virginia Berridge

Transcriber: Debbie Gibson

www.m-c-a.org.uk
**Briefing Note**

The Medical Council on Alcoholism had its first meeting on 20 April 1967 at BMA House. The Council’s formation was an outgrowth of a period of increasing concern about alcohol consumption and a desire to raise both public and medical concern about the issue, in particular at the general practitioner level.

In the 1960s the Council was one of a rising number of alcohol focussed organisations. At the local level the Camberwell Council on Alcoholism was established in 1963 with close connections with the Alcoholism Impact Project at the Institute of Psychiatry which later became the Addiction Research Unit. The National Council on Alcoholism grew out of the activities of the Joseph Rowntree Trust, which had taken an interest in alcohol since the early twentieth century. Set up in 1962, it focussed on regional information and advice centres. Liverpool was the first site and the Merseyside Council on Alcoholism operated from 1963.

There were also older organisations in the field, most notably the Society for the Study of Addiction, dating from 1884. In 1967, there was some overlap in membership and the Medical Council’s first chair, Francis Camps, a forensic pathologist, was also the President of that Society. Members of the first executive committee of the Medical Council included Professor WLN Kessel, Dr Thomas Bewley and Dr Max Glatt, `names’ from the emergent alcohol field. The President was Sir Clement Price Thomas, Secretary Dr H.D.Chalke, MoH for Camberwell, assistant secretary Dr A Minto from Nottingham and Hon Treasurer Dr Noel Moynihan. Shortly afterwards Drs Spencer Madden and D. L. Davies also joined.

The Council’s activities in these early days were ambitious and wide ranging-it aimed to provide research funding; an information and bibliographic service; and panels of expert speakers. It was concerned with education and also with occupational health. It produced a bulletin for practitioners based on the Camberwell newsletter which Dr Chalke had initiated. Finance was an issue and at the end of the ‘60s the Robertson Trust, three anonymous Scottish ladies, began to provide long term funding. Surgeon Vice Admiral Sir Dick Caldwell was appointed Executive Director in 1970 and began to expand and to coordinate activities.

In the 1970s there was greater government interest in alcohol, in particular from Sir Keith Joseph, and a period of DHSS funding of organisations in the field in which the MCA shared. In line with the practice of the time there were donations from the alcohol industry. Activities covered many fields with an Anglo-Irish research project; educational work-films, books and work in schools; and an expanding library and information service.

But there was also concern at governmental level about the proliferation and overlap of bodies dealing with alcohol. There were continuing discussions within the bodies in the field and in government itself about how this issue might be resolved. The DHSS wanted more cooperation in the field and delineation of duties. The 1980s saw the withdrawal of government funding, the abolition of some organisations (NCA, AEC), the establishment of new organisations such as Alcohol Concern and the Alcohol Education and Research Council(AERC) and the emergence of other organisations such as Action on Alcohol Abuse, set up by the Royal Colleges, and the Institute of Alcohol Studies, by the temperance movement.

In the midst of all this, the MCA discussed whether it should continue. It decided to maintain its independence as a medical organisation and a new stage began. A new journal Alcohol and Alcoholism was set up in 1983 with Dr Allan Thomson, Dr Spencer Madden and Dr Abdulla Badaway at the editorial helm. The new `red journal’ replaced the old `blue journal’ the British Journal on Alcohol and Alcoholism which had been distributed free to GPs. The new journal was the journal of the MCA and of ESBRA (European Society of Biological Research on Alcohol) with which the MCA had developed an alliance. The organisation began to comment regularly on government policy papers.
The more recent history of the Council will be more familiar to those attending the witness seminar.

Some of the issues to be considered by the MCA across the decades have been:

- How should the MCA position itself in relation to other organisations in the field?
- What should its role be in relation to treatment provision, to prevention and to early intervention?
- How should it take forward the education of doctors and other health professionals?
- What should its role be in relation to alcohol policy and how should it respond to government and external initiatives?
- How should it develop publications, its journal and research on alcohol?

During the witness seminar we hope to hear your recollections and experience in relation to some of the issues raised here.

**The seminar schedule is as follows:**

1.30pm  
Tea, coffee and cake

2.00pm  
Welcome and introductions

2.10pm  
Panel introductory comments

2.30pm  
Open discussion with invited audience members

3.50pm  
Final comments and close

**Location:**

Princes Room  
BMA House  
Tavistock Square  
Bloomsbury  
London WC1H 9JP

Please also take a moment to read the attached consent form which gives us permission to record the seminar and publish the transcript. If you have any questions or concerns please contact Clare Farrow at the MCA, info@m-c-a.org.uk tel: 020 7487 4445.
Participants:

Chair
Professor Virginia Berridge, Director of the Centre for History in Public Health, London School of Hygiene & Tropical Medicine

Panel
Dr Allan Thomson, Consultant Gastroenterologist, Founding Editor of MCA Journal, Alcohol and Alcoholism
Dr Bruce Ritson, Vice President of the MCA and former MCA Chairman
Dr Brian Hore, Retired Consultant Psychiatrist
Professor Colin Drummond, Professor of Addiction Psychiatry, King’s College London & Chair of the MCA

Audience
Dr Peter Abraham, Former MCA Medical Director
Ms Katherine Brown, Institute of Alcohol Studies
Professor Ilana Crome, Professor of Addiction Psychiatry, Keele University
Miss Clare Farrow, MCA Admin Assistant
Dr Dominique Florin, MCA Medical Director
Ms Diane Goslar, Royal College of Psychiatry Service User
Dr Irene Guerrini, Consultant Lead Psychiatrist in Addiction, South London Maudsley NHS Trust
Mr Clive Henn, Senior Alcohol Advisor, Public Health England
Mr David Johnson, Consultant Psychiatrist in Addictions in Argyle and Bute
Dr Jenny Lisle, MCA Board Member
Professor Susanne MacGregor, London School of Hygiene and Tropical Medicine
Dr David Marjot, Retired Psychiatrist
Dr Jane Marshall, Consultant Psychiatrist in the Addictions, South London and Maudsley NHS Foundation Trust
Professor Alan Maryon-Davis, Chair of Alcohol Research UK/Alcohol Concern
Dr James Nicholls, Director of Research and Policy Development, Alcohol Research UK
Dr Guy Ratcliffe, Former MCA Medical Director
Dr Peter Rice, Former Consultant Psychiatrist, Chair of SHAAP (Scottish Health Action on Alcohol Problems)
Dr Iain Smith, Consultant Psychiatrist, Glasgow, Chair of MCA Education Committee
Professor Betsy Thom, Professor of Health Policy, Middlesex University
Ms Rosemary Wills, Semi-retired Nurse
Dr Simon Wiseman, Programme Director, Primary Care Education, Whittington Health NHS Trust
Dr Alasdair Young, BDDG/Sick Doctors Trust, MCA Board Member
Dr Iain Smith
So I’m Dr Iain Smith from Glasgow, I chair the Medical Council on Alcohol Education Committee um over the last two years and we became aware we were coming up to our 50th Anniversary in the Medical Council on Alcohol and wondered how we could mark this occasion. So we thought a witness seminar, would be a good thing to have. Certainly we’ve got three historians amongst us here. I’ve had an interest in history and I’ve seen some of these witness seminars in Child and Adolescence Psychiatry and Old Age Psychiatry and Social Psychiatry and they are fascinating events to observe. I’m not expecting any fighting here today, but the old age one seemed to get quite raucous, the one I saw in Glasgow, two camps of, rival camps in their youth of psychiatrists who seemed to be still fighting the same battles many years later. But knowing the people in front of you just now, I’m sure this will be very smooth and fair. So Professor Virginia Berridge is going to chair and facilitate this. It’s being recorded. We expect this invited audience to each have a few words if you are so inclined and there’s a hope to write up and keep a record of this event. Also I saw some of you were looking at the materials, therewill be a little time at the end and the posters will be available at the main conference tomorrow, which should be a special day as well. So over to Virginia.

Professor Virginia Berridge
Well thanks very much Iain and welcome to everyone. This morning James Nichols and I were trying to explain to a student what a witness seminar is, and she looked very confused at the end of it. But I’m sure that you all know what it is, it’s almost like a historical focus group where people talk about the past as they remember it. It doesn’t matter, it’s not like a formal academic presentation, you can say what you like, absolutely what you like. But it is being recorded and we can ask you if you are speaking, if you say who you are, because it will be transcribed and it makes the transcriber’s life much easier.

Well the purpose of the witness seminar today is to examine and to some extent celebrate the 50th Anniversary of the Medical Council on Alcohol, which began as the Medical Council on Alcoholism, an interesting change; began in 1967 at a period of growing interest in alcohol and the briefing note which you’ve received tells you something about that. It was a period when a number of different organisations were founded, some of them floundered and others went on. Then in the 1970s the Department of Health got interested and started funding some of those organisations. That was then followed in the 1980s by a period of disruption when some of those organisations folded or were, ceased to exist. But throughout all that the Medical Council soldiered on and it’s reached its 50th Anniversary and during that period too, its journal changed and developed in a very different sort of way. So hopefully we’ll be talking about all of those decades this afternoon and we have four speakers to kick that off, kick that discussion off. We have asked each of them to talk for about five minutes about their memories of involvement in the council. So I’ll introduce them and they’ll kick off and then we’ll throw things open to the floor.

So our speakers are Dr Bruce Ritson who’s Vice President currently of the MCA and was Chairman from 1993 to 2003, but he’s been involved for very much longer and I know that because I’ve been reading some of the minutes. He’s been involved in its affairs since the 1970s and has been on the Executive since 1975. Elsewhere he’s been a consultant psychiatrist in the Alcohol Problems Service in the Royal Edinburgh Hospital, the first Chair of Scottish Action on Alcohol Problems and Chair of the Substance Misuse Faculty at the Royal College of Psychiatrists up to 1998 and also Consultant to WHO. Our second speaker is Dr Brian Hore, a retired consultant psychiatrist who trained at the Maudsley with Griffith Edwards and from the early 1970s he was lecturer in psychiatry at the University of Manchester and in charge of the alcohol treatment unit in South Manchester until his retirement. He’s been involved in the MCA since the early 70s and in particular been active on the Journal Committee. Our third speaker is Dr Allan Thomson who’s a
consultant gastroenterologist and the founding editor of the most recent incarnation of the MCA Journal, Alcohol and Alcoholism. And our final speaker is Dr Colin Drummond, who’s the Professor of Addiction Psychiatry at the National Addiction Centre. He came onto the Education Committee of the MCA in the late 90s and has been its Chair since 2011 and he’s also Chair of the Addiction Faculty of the Royal College of Psychiatrists. So thank you very much for our speakers for being willing to talk and we’ll start with Bruce Ritson.

Dr Bruce Ritson
Well thank you very much Virginia, I’m very grateful to be invited to talk on this subject. It is a long time and I remember I think it was Dick Caudwell was the director who first came to me when I was in Nottingham and involved in the addiction unit there and as you say that was in the early 70s. It’s great to have a witness seminar, witnesses are very unreliable as we all know and as one gets older, memory fades and gets even more unreliable. So I’m very pleased that we’ve got a heap of historians here to keep us on track. So having said I’m um, there’s no doubt about the unreliability and the selectivity of my memory, here are a few thoughts. One of the thoughts I had was how did it all start. The late Griffith Edwards writing about Max Glatt who was in many ways one of the founding fathers of the MCA, said he brought alcoholism in from the cold and I think in a way the MCA brought alcoholism in from the cold as far as the medical profession was concerned. So that was my initial thought about it. But why, what pressures were we responding to? Well as we know there was increasing consumption, there was increasing harm, not just physical harm, but social harm, psychological harm and an interest, a great interest in habitual and drunk offenders in those early days. Um then there was the demand for decent clinical services and I think there was pressure from patient groups and particularly some patients who, or relatives of patients who were prompted and indeed helped set up the MCA. Then of course there was AA and the sick doctors’ groups, there was a coming together of a concern that services were quite inadequate and as you say there was Government concern and that was another important factor in getting us started and to a certain extent keeping us going in the early stages. For many decades we had not only Government interest, we had ministers speaking at one of our events and we had a regular attendance of a representative of the Department of Health and Social Security at our meetings. That declined in the 80s and I think that’s an interesting change. One of the other things was the diversity of medical specialities you’ll see listed in the early days of the MCA, general practice, general medicine, surgery, pathology, well connected members of the medical establishment and a sprinkling, but quite a small sprinkling at first of psychiatrists. I took part in the first international medical conference on alcoholism and I think it was the only one organised by the MCA and Sir Keith Joseph at that time was Minister for Health and Social Security spoke at the opening. So a lot of support. And that’s reflected in the growing number of psychiatrists and specialist services I was a consultant in one of them and Brian as we’ve heard was a consultant in another and they were set up around the country. I think one of the factors was that alcoholism as we were calling it then, was seen as a symptom if you like of underlying psychological disturbance and the psychiatrist’s role was and helped of course by nurses, psychologists, social workers, was to help uncover the psychological problem, so that the patient could go on without drinking. So the focus on the individual was pretty prominent at first. That was reinforced by the Government’s circular, I think in 1962 there was a Government circular on hospital treatment for alcoholism which influenced that trend. So the MCA was emphasising at that stage, raising awareness amongst, particularly amongst doctors, but also other healthcare professionals. Education, student seminars, we had some very successful ones in Scotland that had students, not just medical students, but occupational therapy, nursing and other students and also a focus on services, on the importance of providing services for people with alcohol problems. I think our main emphasis increasingly over those decades was education and Ilana Crome who is here today was very prominent in pointing out to medical schools the dearth of education about alcohol in the medical curriculum and we certainly used that to try and promote more education to undergraduates. We set up medical advisors, I think there were about 30 of them in each of the medical school areas and um, we prepared a number of handbooks on alcohol and health, which I wrote with Marsha Morgan, who was a great friend of the MCA and also we had a handbook for nurses and done for general practitioners. Some of them are on the
back table there. And that was very much the emphasis for a long time. Then I think and we’re probably talking about the late 90s there was a reframing of the problem. Away from the saying well what is it about the individual and the harm that or she suffers, but what about the substance itself, why are we not focusing on alcohol itself. It was around this time that we changed our name to the Medical Council on Alcohol rather than Alcoholism. I can’t find when that actually happened, but maybe as a historian you can help me. Somewhere in the 90s, I certainly remember us talking about it endlessly. Then the emphasis came to primary preventions and there was a kind of a move upstream in our thinking. We were focusing much more on per capita consumption and there was a broadening of the treatment base to include a much wider range of participants, primary care particularly. There was an interest, a growing interest in early recognition and brief intervention, guidelines became an issue, an activity, the MCA had views about the guidelines and gradually the emphasis shifted, perhaps we all think it shifted too far, towards um that primary prevention and there was always the worry that one might be neglecting the people who had suffered most and were the original stimulus to the MCA; the patients coming through casualty departments, coming through liver units and psychiatric services with much more advanced problems related to alcohol. So maybe that’s a dilemma we’ll come back to. But that’s been the sort of journey as I’ve seen it.

Professor Virginia Berridge
Thank you very much and now we’ll go straight on to Brian, Brian Hore.

Dr Brian Hore
Yes I joined the Medical Council in the early 1970s and have been a member since. The view of the Department of Health around that time was that, as Bruce has said, was that alcoholics drank because they had psychiatric illnesses and therefore they should be treated in mental hospitals by psychiatrists. The 60s was a good time in this field. We had as Bruce said involvement by the Department of Health in forwarding the work of the Medical Council. They would come to our committee meetings and take a considerable interest. And they had a full team that dealt with alcohol, drug and homelessness and they were very encouraging towards the Medical Council at the beginning. There were four national bodies at that time. The National Council of Alcohol which provided walk-in advice centres. The Alcohol Education Centre based on the Maudsley Hospital where education for a wide group was provided, The Federation of Residential Establishments, which enabled half-way houses to be developed and the Medical Council was the fourth one. The Medical Council had been set up, as we’ve already heard from Professor Berridge, by a group of doctors, the great and the good you could say, they were some very eminent doctors. If you look back who was on it, it was ‘sir’ this and ‘lord’ that, not just that, but they certainly went for the great and the good and also some lay representatives, including a film producer and an entrepreneur who gave money in this field widely and had already formed one of the other charities in the field. The Medical Council was predominantly interested, originally in, as Bruce said, in treatment, but then it moved more towards prevention. It provided facilities for using for teaching. The concern was the teaching should be both of medical students as well as doctors. A study by a man called Wilkins in Manchester found that 90% of the alcoholics in a general practice, were unknown to the GP. Mind you some of course didn’t want to be known to the GP and the GP didn’t want to know them. But there was no doubt that there was virtually very little education in the field. One of the ideas that really got off the ground was the idea of having regional advisors. That means that in each area of the country you have regional advisors, experts from the Medical Council, who go into the medical schools and teach the students. That met with some opposition and the academics here might not be surprised, why should other people come into our medical school and try and teach our students. So that wasn’t totally successful, although it was in some medical schools. Edinburgh was a good example of where it was successful. There was however some hostility to that idea. Now the Medical Council had two problems in its early years, one was whether to stay as a single entity, or whether to merge, particularly with the National Council on Alcohol. They decided not to do that. But the more serious problem was money, as with all charities it’s very difficult to get money and if we hadn’t have taken money from the Scottish drinks industry, we wouldn’t be sitting here today. That was not a controversial point.
then, I don’t know if it would be today, we’ll perhaps find out. But the Scotch Whisky Association, the Robinson Trust were alcohol organisations that gave money to the Medical Council and without their money the Medical Council wouldn’t have survived. The Department of Health, I don’t know whether they got disillusioned or they thought it was too much, they thought four organisations was too many. They wanted to reproduce it with one national body, which happened with Alcohol Concern. They did this by withdrawing grants of the four organisations I’ve mentioned. So two of the organisations closed immediately. The Medical Council decided to try and carry on, although there was a limit to how long we could go on for. But it was hoped that some sort of funding could be found, apart from what had already happened. And the MCA did not close, but it always felt that there was a closure date. We used to have at meetings that we could only go on for two more years, three more years, before we’d go under. At any rate it kept going and that’s why we’re here today. The saving of the Medical Council in terms of money was through the sale of the journal. Half the journal has been sold to Oxford University Press and it’s a very prestigious journal under the direction of Professor Chick from Edinburgh and Professor De Witt from Belgium and Allan Thomson of course was strongly involved in that. With this money which we now have, regular funding, it is guaranteed we can continue. In fact there is no reason why we shouldn’t have another reunion in 50 years.

**Professor Virginia Berridge**
Thank you very much. And now Allan Thomson.

**Dr Allan Thomson**
Yes thank you. Well my primary involvement has been with the journal, the two journals since 1980. The first journal which the MCA produced for the general practitioners was this little blue journal which started in 1967 as a single photocopied sheet and gradually quite rapidly over the next ten years, a very interesting period it was distributed to 222,000 different practitioners. So just to put this in context, in 1963 I graduated from Edinburgh University and I was working with Professor Girdwood, when I was invited to go over to the States extensively for one year. In fact, I stayed six years and became an assistant professor and came back through Oxford with Sir Hans Krebs and joined the liver unit here before deciding to stay back in this country. I was invited by the then editor of the blue journal, Dr Myrrdin Evans to become deputy editor and I didn’t realise at that time that in fact he was going to leave about two years later and so became editor of this in 1980. But his and my interest in that of the Medical Council which really turned the journal into an international multidisciplinary research journal and to have at the same time a different journal which met the needs of the general practitioner. So in 1980 we set off and it was quite an interesting story, to find a publisher and I can tell you all sorts of things about this. And we had to get it funded and we had to get all the instructions to authors and all, everything that is required to set up a new journal and this was at a time when there were no computers, no emails, no faxes and no mobile phones, which I rather difficult to conceive at this time. But we did have one manual typewriter, one landline telephone and I had got quite a lot of contacts in America which was very helpful and we can talk about that later, to set up an American office. And we had one secret weapon which was Wendy Howard as she was at that time, really took over the whole administration and running of the journal and whom I subsequently married. But um, so that really is where I’ve been involved.

**Professor Virginia Berridge**
And now Colin.

**Professor Colin Drummond**
Thanks very much. I thought I would just reflect on my own experiences with the MCA and with the field perhaps more widely and looking back over the last 50 years, the MCA story and the story of our wider field in alcohol has probably been that of a great success in the UK and we don’t often appreciate that. When I trained in Glasgow in the 1970s and graduated in 1981, by the time I came out of medical school, I had had one hour of training on alcohol and this is before the MCA got its teeth into Glasgow University, which it now has a much stronger curriculum. But alcohol
was fighting with everything else on the medical curriculum for a space in people’s training. So by the time I got my first job which was in the Glasgow Royal Infirmary A&E Department, three things became very quickly apparent; one was most of the people I was seeing had a problem with alcohol, the second one was that I hadn’t a clue how to help them and the third one was that they were a highly stigmatised group of patients. And so in many ways it’s remarkable that after one hour of training that I actually ended spending up a career in the addiction field and specialising in alcohol. After that I went into psychiatry training in Glasgow and like probably many people in this room, I had the benefit of being trained in one of the regional alcohol treatment centres. This one was in Glasgow run by Patrick Mullen. But I benefitted not just from one, but three regional training units, because subsequently I worked with Griffith Edwards in London at the Maudsley and I had my first consultant job working with Hamid Ghodse at St George’s. All three of them highly inspirational clinicians who inspired a whole generation of people to go into this field when everybody else was advising them not to. But from that small group and perhaps at the time I began training there was about maybe 15 or 20 addiction specialists in the UK, that grew by 2006 to 239 consultants in addiction psychiatry in the UK, 190 of them in England, 23 in Scotland, which is a remarkable increase in the space of only about 25/30 years. At the same time the number of training places for people training to be specialists, at a specialist registrar level, had gone from a handful up to 157 in 2006. We had in that year 52 people achieve specialist certification from the GMC in addictions and until this day the training, the psychiatry training route is the only way to become a medical specialist in addictions in the UK, there is no other route. A lot of that was on the back of considerable investment by the Government of the 2000s onwards and mainly to do with drugs, alcohol was a bit of a neglected subject, I think compared to Class A drug misuse. So a lot of money was pumped into preventing drug-related deaths and more particularly drug-related crime. But the alcohol field I think benefitted a little bit on the back of some of that. However we are now in a period of decline and a very rapid decline at that and that is something of great concern to me through the Royal College of Psychiatrists, but it should also be a concern to us in the Medical Council on Alcohol. So we went from having 52 trainees in addictions in England in 2006 to 21 last year and that’s a reduction over the space of ten years. So basically the pipeline for people specialising in addictions is going to dry up fairly soon if we don’t reverse that. The other big decline that we’ve seen is that all of those, almost all of those regional addiction treatment units in England which we had and trained most of us psychiatrists in this room, we had 8 in London in 2008 and now we have no units at all in London and the picture is similarly bleak in the rest of the UK. Those units not only provided treatment for people with alcohol and drug problems, they also provided essential training and research resources and they have all been dismantled bit by bit. A lot of this is to do with Government policy, which has been to basically leave the whole thing to market forces and money for addiction treatment is put into the hands of local authorities at the very same time as the Government started cutting local authority budgets. So it’s no surprise that it was reported on the BBC last week that since 2013, 350 million has been stripped out of the addiction treatment budget, just in five years, four years that is. That is about a third of the expenditure. So not a particularly good picture. But you know these things probably come in waves. We started from a very low base when I first came into this field and we haven’t quite gone back to that point, but my expectation is that the pendulum will start to swing back in the other direction sooner or later. It might be in response to the continuing epidemic of alcohol related deaths which I see in the news today are increasing again this year, liver deaths are up, hospital related alcohol admissions are up and drug related deaths are at the highest point on record, having doubled in the last three years. So we may find a situation where it’s actually impossible just to ignore this problem and something may have to be done. We also, perhaps optimistically, maybe I’m being unrealistic about this, but having been involved in lobbying on alcohol policy issues for many years, 13 years, we’ve gone from a situation where it seemed that the Government wasn’t listening at all, to a situation where we have at least two jurisdictions in the UK that wish to take some significant action on the price of alcohol and in particular the cheap alcohol that is being sold. I’ll find out through Twitter or something else tomorrow hopefully what the outcome of the Supreme Court decision is. But it’s actually taken all those years to get to a point where you actually have a Government department accepting the proposition that the price of alcohol is an important way to control harm and Public Health
England just at the end of last year published a very important evidence review on all the policy options in alcohol and that to my knowledge is the first time a Government office has actually acknowledged the link between price of alcohol and harm. Treatment I think is going to take a bit longer, certainly not under this particular Government are we going to see much change, but it's very interesting to look across the Atlantic where the US Government is moving in precisely the opposite direction to England and is trying to bring addiction treatment into the mainstream of medical care through Obama Care and various other provisions. And the surgeon general's report from the US published towards the end of last year, suggested that if you don't address addictions, it's actually going to cost you a lot of money in the long run. So a very strong advocacy and programmes springing up across the US, to train people, not just psychiatrists, but other physicians in addiction skills are growing. Harvard has just opened a big new programme. So I think um you know we can reflect on some very positive things that the MCA has achieved, so getting education into medical school which ultimately over time will bring about change. We have also been active in advocacy and I think many of the people in this room have been pivotal in pushing for change in policy. And we've also been advocating for treatment and I think we should continue to do that.

Professor Virginia Berridge
Thank you very much, thanks to all our speakers. We can now throw it open to the floor, to anyone who would like to contribute and the briefing that you received has got a number of themes that the member of the council particularly wanted to hear about, one of which was the changing response to treatment provision, another one on the education of doctors and other health professionals and a third one about the policy involvement of the Medical Council. So I think perhaps we could start by talking about the Medical Council's role in treatment and the changes which have taken place in treatment and it would be nice to hear from somebody whose memories go way back. Is there anyone in the room who can remember the 1960s or the 70s? We've heard a little bit about that from our speakers. Somebody is pointing to you? If you could just say who you are.

Dr David Marjot
Psychiatrist, long retired. I first became aware of the MCA in 1968 and I must have joined about that time or soon afterwards. The army and navy had a joint psychiatric treatment unit, which was very closely based on that of Max Glatt at St Bernard's Hospital and it was quite well known for a time that most AA groups around naval ports was run by the Navy. But we had a joint service unit then. I found working in a military general hospital looking at the servicemen coming through, all the specialities, but the hideous damage inflicted on the Royal Navy by alcohol. I estimated that about a quarter to a third of all senior ranks, that's Senior NCO's were leaving the service because of alcohol problems and as a result the knock-on effect was they abolished the rum ration in the navy, which was, then allowed them to drink more, which just goes to show that cosmetic policies don't work. There was a shift, like a, anti-psychiatry came in, in the early 1960s. Psychiatry had a high status at the end of the Second World War, because psychiatrists had kept psychiatric casualties to a minimum and had treated people close to the front line in open units, not in mental hospitals. And when the psychiatrists came back from the armed forces, I was just too young to join the armed forces during the war, they proceeded to change the mental hospital. I joined the mental hospital in 1958 to start the profound change in opening up the hospital and beginning to shift it to community care and reducing the numbers of patients. So when the MCA psychiatry came along in the early 60s, this reform process was well under way and unstoppable and unfortunately it got, the two were conflated and that sort of thing. So there was a considerable impetus on specialist units, firms I think they might have been called in medical terms. Then there became a tendency to think that specialism, there was a general anti, the student uprising in Paris was a good example in the, much of the, the disparagement of specialities and specialism and special units, particularly in behavioural work. And gradually we have seen a shift away from the intensive care of the sick patient to um, to cheap and easy and particular with privatisation there's been a drive to employ people as cheaply as possible to provide care as widely as possible and as inexpensively as possible. So I think we've seen quite
severe damage done and it doesn’t look like it’s being reversed at the moment. But it was ... sorry?

**Professor Virginia Berridge**

Do you have some memories of the Medical Council in those days?

**Dr David Marjot**

It was great fun. I think, I remember myself talking to my colleague psychiatrists and the last thing we wanted is a fall in the hands of psychiatrists. We were all acutely aware I think, particularly with alcohol, the hideous damage inflicted on people, their livers and their hearts and their brains, quite apart from anything else and it really was an all speciality effort and psychiatry was only a small part of that shift and I think the great joy of the Medical Council on Alcohol was that it brought together the medical profession as a whole, to work together, which even now is relatively unusual. I think it’s quite difficult to persuade colleagues to take alcohol and drugs seriously in their patients. I enjoyed it enormously, it was a very rewarding organisation to belong to and a great support.

**Professor Virginia Berridge**

Thanks very much. Has anyone else got memories from those years, or the 70s about treatment or educational work? Yes.

**Dr Jane Marshall**

It’s not a MCA memory, but it’s a memory as a medical student. I think coming up, continuing David’s theme of the navy and as a medical student in 1976, I came over with a couple of friends and did an elective at the Royal Naval Hospital in Haslar, down near Portsmouth and there were a number of things that struck me at the time. One was that I was just learning how to take histories and I was let loose with my colleagues, my medical student friends from Dublin, we were let loose on the wards, to take history and I very really quickly realised I had to learn how to take an alcohol history, because there was so much alcohol morbidity. And I vividly remember one little old lady, being admitted acutely and having an abdominal perineal resection and went into the DTs and the naval doctors were all rather gun-ho and treated her with intravenous alcohol, because they did this on board ships. And it was a tremendous learning ground in relation to alcohol. But in relation also to the day to day use of alcohol. In the officers mess the bar was open at lunchtime and a gin and tonic cost 2p and everybody went and had a drink. Everybody went to the officers’ mess and all the doctors drank and I was just amazed and of course you could pick up those doctors that were drinking rather too much and by 2pm were not going to be able to function in the afternoon. I don’t know whether that was why I became interested in doctors with drug and alcohol problems, but it was very cheap the alcohol in the navy.

**Professor Virginia Berridge**

And what period was that?

**Dr Jane Marshall**

This was 1976.

**Professor Virginia Berridge**

Yes. So how did that lead into your involvement in the council?

**Dr Jane Marshall**

Well I then came to, I then trained as a psychiatrist in Dublin and there was an alcohol unit where I worked and then worked at St Bartholomew’s as a liaison psychiatrist, but they had opened an alcohol outpatient clinic there, because they realised there was a major problem with, there was Fleet Street nearby and Smithfield Market and all the pubs opened at 6 O’clock in the morning. So we, St Bartholomew’s was a fabulous place also as a liaison psychiatrist to learn about alcohol. But it was really only in the late 80s when I moved to the Maudsley and was a colleague of Colin’s
where I actually began to learn about how to manage and treat alcohol problems on the alcohol unit and that was my way in to the MCA. And then over the years through reading the red journal, Alcohol and Alcoholism and then latterly writing articles with colleagues here like Irene Green and Allan Thomson on Wernicke’s Encephalopathy which had been an interest of mine back as a medical student in Dublin.

Professor Virginia Berridge
Thank you. Yes.

Professor Alan MARYON-DAVIS
Currently a quasi-academic at Kings College London in public health, but I’m also currently chair of the Alcohol Research UK/Alcohol Concern. I just wanted to reflect on something going back to the 70s when I used to work as a medical officer at the then Health Education Council. So this is really about education of the public more than anything else. But one of the problems that we had there was that the agenda was being driven largely by the Home Office, rather than Department of Health and the Department of Health had a very light touch approach to the whole alcohol thing in terms of educating the general public and the whole public health agenda. They tended to pass things over to the Home Office to drive it. In the late 70s when I joined the Health Education Council, most of, the thrust of what they were doing in terms of public education was smoking which was the big issue that dominated things, but also a new campaign that came in called ‘Look After Yourself!’ and that was around healthy eating and physical activity. That came in I think in 1977 or 78 was the first year of that national programme. It was the biggest public education campaign in the UK ever at that time. The following year I think they also tacked on tobacco into that same brand, ‘Look after Yourself,’ but alcohol really didn’t get a look in for a few more years after that. Then they brought in a campaign called ‘Know your Limits’ which was based on the CMO guidelines pertaining at that time and that was a relatively modest campaign, mostly through posters and leaflets, nothing grand, there may have been some TV, but I can’t quite remember that. But I believe that people on the planning group for that campaign included the Medical Council, I seem to remember them being around the table when we were planning that campaign. So there was some education going on at a national level, but relatively modestly and most of the funding around alcohol and the drive was centred around the criminal justice system and the Home Office.

Professor Virginia Berridge
Thank you.

Professor Susanne MacGregor
Just to pick up on this discussion about the 1970s, my contact with the issue came in the years 1970 to 1972 in particular when I worked with John Wing at the, and David Tidmarsh and a study of Camberwell Reception Centre and that was the period when the Department of Health and Social Security was, you’ve talked about the sort of waning interest of the Department of Health in this topic, at that point when you had the connection with Social Security there was an interest in the number of homeless people and people dependent on social assistance, who were coming into the, becoming a problem for Government. So there was a period when Health and Social Security were more closely linked when the Department of Health became interested, but it was mainly because of the issue of homelessness, and also the general contextual question of the closure of the large hospitals and other institutions which has been mentioned. So the so called move to community care and the lack of community care and the awareness that there were large numbers of people who were not receiving any treatment at all. When we did that study what was interesting was that it was found that something like, you know a third to a half of the homeless men were in fact dependent on alcohol and there was nowhere for them to go. They were, the Salvation Army were one of the few groups that took an interest and they did have treatment provided, connected to the Salvation Army and certainly there were also GPs like Dr Ollendorf and his group at Camberwell. So there were voluntary organisations and with some GPs and others connected to them who would provide treatment and Camberwell Reception Centre itself
had a wing which was providing treatment, a kind of treatment and care for people with severe alcohol problems and when they got really to the end of their progress, there was an attempt to find them sheltered accommodation. But it was completely lacking, I mean the general picture was one of a lack of provision and then when the Department of Health and Social Security separated, it’s interesting that as you’ve noticed the Department of Health seemed to become less interested and it was only later as has been mentioned when drugs became a rising social problem that the Department of Health became interested again.

**Professor Virginia Berridge**

Thank you.

I just wondered if I could add a little bit.

**Professor Virginia Berridge**

Could you just say who you are?

**Dr Jenny Lisle**

I’m on the Medical Council on Alcohol’s Committees for Education and Executive, but my background is originally in social medicine and talking about the School of Hygiene and also public health, but particularly with an interest in the working population and also the work place and alcohol is very common there. But going back to the early days when I was doing a house job at UCH actually in respiratory medicine, one of my areas was to deal with the tuberculosis patients of which there were not that many at that time. But having just heard Virginia say about the, there was nowhere for them to go, reminded me that in those days there was a large number of those cases came in, in the winter months, because they had nowhere to go. But they nearly all had alcohol problems and that’s probably when I first came aware of it, this link with chronic disease and that they were living rough in London. Some of them did go to Rowton Houses I think they were called. There were one or two knocking around in Covent Garden and other streets and, Vauxhall and so on and they weren’t really treated for their alcohol at that time it was more the tuberculosis that was there. So then I didn’t, after that I didn’t, suppose my first contact with the alcohol problem came when students, it used to be that there was a culture of going to the student bar after classes and um because the alcohol was cheaper in the student bars, that’s when quite a number of people I think became addicted to it, in early addiction. I remember thinking later on when I was doing more of the occupational health work, the commonest problem one saw in the workplace was related to alcohol, but it didn’t present like that, it presented more as a work performance problem, erratic behaviour at work, problems with other employees and so on. So I thought that I needed to get some education in this field, because at medical school I have to say there was very little, possibly none at all, I’m not sure, maybe about an hour or two at the most. That was when I first came into contact with the Medical Council on Alcohol because I think someone suggested that that would be where I would perhaps be able to learn a little about it. So that probably wouldn’t have been until the 90s I think. But there was a long gap. I think that it’s really important to look at the student population because several of my colleagues, well colleagues, contemporaries they were at medical school, later did actually develop quite severe problems and quite a number of them have died and every time I raise this with people, it’s like well that’s very surprising, we don’t know of anyone who has had an problem. But I don’t think it can be exceptional if I should have come across it. And I saw the problem develop over the years in a way and there was no means at that time of really addressing it. So I think prevention, which has been too little tackled really in this field really needs to start early and recently the medical students of the BMA at their conference actually passed a motion to say that they felt all the medical school should have policies on alcohol, to provide the right sort of ground rules for them when they were students, because there are now these very much more rigorous GMC requirements for fitness to practice on qualification. And it’s fine that there’s more education going on, but that needs to be complimented by something such as a pretty simple straightforward policy which is actually implemented. And the survey we did a few years ago rather showed up that the medical schools were still very patchy and only some were doing
something and others were if you like sheltering under a much broader policy for universities, whereas doctors do actually have very specific requirements that other students do not. I could go on a bit, but I think it’s time for someone else. Thank you.

**Professor Virginia Berridge**

Thank you very much. So you’ve raised very interestingly the issue of education and I think you wanted to talk about that?

**Dr Alasdair Young**

Yes among other things. I’m a retired consultant psychiatrist and I’ve served on the executive of the MCA for what 15 years I think. So my involvement with the MCA unbeknown to me goes back earlier than that. To reassure Dr Marjot the reason I’m on the MCA executive is not because I’m a psychiatrist, it’s because I’m a recovering alcoholic doctor. That’s the thing I want to mention here in this witness thing. I crashed and burned in 1988 and was then introduced to the British Doctors and Dentists Groups and when I went into them, I was surrounded by fellow recovering alcoholic doctors, most of whom had graduated from St Bernard’s and fallen under the influence of Max Glatt and a few others. Indeed I was taken up to London and introduced to Max Glatt because I was persuaded that my own chances of recovery would be improved considerably if I became involved in helping other doctors get better as well. That was the very beginnings of my involvement with the MCA. I was to learn that the MCA from the beginning had played a quiet, but significant role in facilitating doctors with alcohol problems finding appropriate help and getting well. Max Glatt had a lot of influence in that. But there were others and some of them are here today who were quietly getting on with helping. And for a very long time and really up to today, the MCA office telephone number was the main portal for doctors with problems with alcohol trying to find out and happily because the MCA was not funded, or owned by the Government or a Royal College, or any other big body, it was perceived by us frightened alcoholic doctors as being safe, because it wasn’t part of the GMC or the BHS or the Department of Health or anything else. So you were safe and I don’t suppose any record was ever kept on the number of telephone calls you received from doctors with problems of their own. But over the years it must have been an enormous number and a significant number of those people got well as a direct consequence of what was happening. One of the later spin offs of this, Colin Drummond, I went to Glasgow University as well as a medical student and we spent a lot of time studying, but only an hour of that was on the curriculum. Happily these days the recovering alcoholic doctor community has become involved very often in association with the MCA in giving presentations to medical schools and it comes under various headings, it can come under self-help or probity, all sorts of things, it doesn’t really matter. But this is a growing thing and it’s nice that we are able to do give something back, but really what I want to do is record the gratitude of the recovering doctor community for the role that MCA has played in, at a personal level, getting an awful lot of us, enabling an awful lot of us to find the help we needed. But going on beyond that to facilitate the teaching and training of alcohol as it may affect the individual doctor to medical schools. As long as I can remember now there has always been a, at least one recovering alcoholic doctor on the MCA executive which says something about the importance that you attach to what we can give back, which is important for us. So I really want to record our gratitude for what you have done and hope to go on cooperating with you in the future. Thank you.

**Professor Virginia Berridge**

Thanks very much. Yes would you?

**Ms Diane Goslar**

I’m a service user, recovering alcoholic and I’d like to link to the last two speakers if you like. I wanted to talk about, I read that one of the themes of the MCA was the education of health professionals. First of all let me just say that I’m involved with the MCA on the outside if you like and I’m very grateful and the MCA does help me. I first got to know about the MCA through Colin, because I do quite a lot of work with the Royal College of Psychiatrists and Colin was the Chair of the Addiction Faculty and that’s how I first got to know about the MCA and I’ve been
coming to conferences quite regularly ever since. But my point about educating and health professionals was I think it’s quite useful that when people are at medical school and they are being educated about the problems of alcohol, that they can actually talk and listen to service users, whether they be doctors who are recovering alcoholics, or recurring alcoholics and um I talk to St George’s medical students on a regular basis about what it is like to be addicted and what helps in your treatment and I think that’s quite useful. So I just wanted to say thank you to the MCA for the help you give and I enjoy being here.

**Professor Virginia Berridge**

Thanks a lot. I can see another hand up over there.

**Dr Simon Wiseman**

I guess I’m here because when I was a medical student I met Max Glatt. At that time when we did our psychiatry attachment, we had one session in the drug clinic at UCH and I guess that was around 1969/70. So I went along not knowing anything about anything, um and I found myself sitting in a clinic with Max Glatt, who was a total inspiration. I said could I come back next week and I then repeatedly went back and spent many months going on a Wednesday, late Wednesday afternoon to his clinic at the drug clinic. And then I spent time on the unit as it was at St Bernard’s then. When I qualified I thought I might work full time in addiction, but for various reasons I had a shift and I went into general practice and academic general practice. But I was very fortunate to be offered a post on the unit at St Bernard’s and Max essentially became my teacher and mentor and he encouraged me to get involved with the MCA and I guess, I think I was on the executive, late 70s, maybe 80s onwards. I was one of the GPs on the executive and I remember there were two others at that time. I’m not entirely sure how many there are now, but I’m delighted to see that first of all the Executive Director, a) is a GP and we have certainly moved into the 20th Century, if not the 21st Century by recognising that we’ve got a female executive director with a general practice background. I think that’s a great thing to have achieved. In my teaching at UCH in the department of primary care, I always found the MCA very helpful to facilitate initiatives and are a great resource and background. So let’s look forward to the next 50 years. Thank you.

**Ms Rosemary Wills**

I’m Rosemary Wills and I work as a semi-retired nurse at the moment and I first became interested in the MCA at the RCN congress last year when I visited a stand. And I’m quite interested, and I had a grandfather with alcohol problems and I’ve helped people on wards, mainly people who are detoxing and I’ve observed their problems and it seemed the biggest problem they had, it seemed they couldn’t get to meetings on time because they weren’t in a fit state and they could only get to these meetings you know when they were sort of tanked up. So that was difficult accessing all these day things, you know they just couldn’t get her there. So I helped one or two into these residential detoxes and really the only way they could go, they had to be taken in a car and the last, I did help a friend and the person who was driving, he was a recovering alcoholic and he was, he got involved in these private places that are dotted around. The only thing is they are so expensive and I think it was about £3000 for a week, but it seemed to be quite effective once the person decided that’s what they wanted. But also the other thing they seemed to say everybody’s doing it and it seemed to be a cultural thing you know they sort of travelled abroad and they were all in Italy and Spain and all drinking. I went to this Christmas meal at the Holiday Inn and they more or less have alcohol on all the tables and I can’t drink because I suffer from migraines, so my sister had to drink all this wine and it’s more or less there you know whether you want it or not. So I think some of it could be to start off with cultural.

**Professor Virginia Berridge**

And you became involved in the Medical Council?

**Ms Rosemary Wills**

Well I’m thinking as I’m semi-retired it’s an area where I’m thinking how can I get involved and I do reflexology as a volunteer at the Stress Project in Islington where a lot of recovering, a lot of
women are recovering and it seems to help them relax and I’m thinking of how to get more involved. I did do a course with the MHRA about brief interventions and that was very, very good I thought, but that was sort of an online course. But I’m thinking perhaps I could do some volunteering with the Salvation Army or something like that, you know sort of on the frontline. I prefer the frontline really.

**Professor Virginia Berridge**

Thank you very much.

**Dr David Johnson**

Consultant psychiatrist in addictions in Argyle and Bute. My first exposure to the MCA was unbeknownst to me, I was a medical student in Aberdeen in the late 1980s and in between the pre-clinical and then clinical years there were an introductory set of lectures. A doctor appeared at early morning lecture and was scheduled to speak for one hour on the effects of alcohol. I was relatively inexperienced, was a mature student and didn’t receive the ground common with students of today and I was aware that there would be a large number of handbooks that would be free of charge to everyone attending that lecture. And those handbooks were excellent, as was the talk from the speaker, who in retrospect I imagine was circulating around medical schools in Scotland, perhaps the UK, describing how alcohol had affected the occupational personal life and raising the awareness of the risks that alcohol may pose. That was quite an inspirational lecture and the handbook was excellent. But there were very few handbooks that were given free of charge at that time and I was then aware that alcohol could affect so many aspects of physiology and appear in so many different medical specialities. I wouldn’t go as far to say that I passed my medical finals with the alcohol health handbook, but in many of my clinical attachments, I would be able to draw on the knowledge that we had from that handbook. Subsequently I trained in psychiatry and specialised in addictions and you know worked very hard with a particular medical school in Scotland who ensured that its medical students will receive copies of that handbook.

**Professor Virginia Berridge**

Could you say a bit more about that because I think it’s the first time we have heard that mentioned this time?

**Dr David Johnson**

It was really difficult. It was Dundee University so it was quite difficult because I was on the opposite side of Scotland to Dundee University and my involvement would be only with students on psychiatric attachments in Argyle and Bute. But I was aware from the students that came on psychiatric attachments in their fourth year of medical school that they had, not had the same opportunity that I’d had at Aberdeen University of a person speaking to the medical year. It’s more difficult now in that it’s unusual to have a medical year altogether for one lecture with everybody present. So I understand it’s more difficult to have such an opportunity, but along with Peter Rice and the tutor at Aberdeen University responsible for psychiatry, we were able to eventually get copies of the handbooks to the medical school and students would present at and sign for. So it wasn’t quite the same delivery, but students were getting the handbook.

**Professor Virginia Berridge**

So it was difficult to get hold of?

**Dr David Johnson**

It wasn’t difficult to get the handbooks, it was difficult for several years to get the message across to the medial school and then the students to actually get into the medical school office to sign for them.

**Professor Virginia Berridge**

And I think you’re now a regional advisor, do you want to say a little bit about that role?
Dr David Johnson
I’m not actually a regional advisor. (Laughs.) It would be tricky because as I say I’m on the West Coast of Scotland and in a pretty remote and rural area and my exposure to the students from Dundee University is limited to two students every four weeks.

Professor Virginia Berridge
Right thanks very much.

Dr Betsy Thom
I wanted to go back to the, is that better?

Professor Virginia Berridge
Yes.

Dr Betsy Thom
I wanted to go back to the theme of education and training and to something that Bruce noted in his comments, the tremendous shift that’s taken place over the 50 years from a focus on treatment, to a focus on public health and early intervention. And along with that shift has gone a huge shift in the work force, who are expected to respond to problems of alcohol. And that workforce has expanded well beyond the medically trained professions, to include people like for example, housing officers, social workers, youth workers, people in the criminal justice system. We’ve been doing research with them recently and what they tell us is that yes early intervention is fine, they could maybe do it, but what they’re bringing up is dependence and severe drinking and that they don’t know how to deal with that. So the educational needs today have gone beyond training medical professionals and allied health professionals, to this much broader group and they’re also, there is also a problem of a disconnect between these services and the, knowing where to put someone who has got a dependent problem. So when you mentioned has it gone too far, is treatment being neglected, maybe those professionals would say yes, because we don’t know what to do with people with dependence problems when we find them and there’s no support. So those are issues that might be of interest for the MCA going forward and thinking about its education and future activities, because it’s a very lively issue in the field today.

Professor Virginia Berridge
Thanks very much Betsy.

Dr Iain Smith
Thanks Betsy, consultant in Glasgow. When I look at the early minutes of the MCA, it was a real surprise to see that it was very concerned with the setting up of the treatment facilities around the country, or it was reflecting the setting up of those facilities. The unit I work in now gets a mention that Dr Peter Kershaw, it’s now called the Kershaw Unit. So there’s a Ritson Unit, there’s a Hope Unit, I think there are various units named after those seminal people setting them up. The MCA was so concerned with setting up services, because when I came into the world of the MCA, I think I had it entirely bracketed in my head as being about education and somehow elsewhere would be the concern about how treatment services were running. But, so I think it is refreshing that it was there and maybe it should be there again, given some of the discussion we’re having. I think the services for alcohol dependence have been asset stripped. I wondered, I was trying to cast my mind back, the famous Griffith Edwards and someone else experiment, brief intervention versus intensive treatment and the Department of Health picked that up and put out some massive saying really you don’t need all these intensive treatment facilities, you know brief advice can be just as good. Was that in the 80s? Did that do a lot of damage or was that just an excuse? I mean David over there his hospital lost its alcohol treatment in Scotland in the 1990s or late 80s I think.
Dr David Johnson
2002

Dr Iain Smith
So the very issue in itself being, I mean Scotland has generally held onto units, but I mean one was very aware in England that these units were closing. All my colleagues who were in this field in England seemed to revert to being general psychiatrists and units were lost. I kind of, when I tell the story of the early history and whether it’s right or not, I’d be interested to hear you know was it an emerging need within general psychiatry to set up these units, or was it only partly that and there was a need from elsewhere, from out of the psychiatric world, because the way I heard the story was there was lots of people in the psychiatric wards who were, whose main problem was alcoholism and therefore what would you do then to help that individual if there wasn’t a facility. Was that the main reason that all these facilities came into being I wonder. But certainly now I feel the alcohol treatment world that I’ve been used to being in, in Glasgow is under threat, partly from drug treatment. There’s a kind of robbing Peter to pay Paul within generic addiction services. So I think we have to think, can we, where can we fly the flag for the needs of the severely alcohol dependent and the need for that more intensive treatment that’s got lost in the general system.

Professor Virginia Berridge
Thanks very much Iain, lots of questions there. Somebody who’s, would you like to say something because you were involved in the council, in the 90s weren’t you, do you want to talk about your reminiscences.

I am wondering what you want me to talk about.

Professor Virginia Berridge
Just speak into the microphone. Would you like to say who you are?

Peter Abraham
Um and yes, in the army I’d been learning about alcohol in psychiatry in the alcohol treatment unit in Italy and subsequently in Germany 1 in 10 of my patients had an alcohol problem. So I think that um, I just thought if you, I might mention my first predecessor the person, the first medical director was Brigadier Glynn Hughes and please correct me if I’m wrong about this, he had served in two World Wars and then his last job in the war was looking after Belsen and then he rescued the Commander’s desk from Belsen, because everything was put to flames and it became the first desk used by the medical director in the Medical Council on Alcohol. When he left he gave it to the Royal Army Corps Museum. Yes I think, I’ve heard people talking about education of doctors and I think this is really one of the things we did concentrate on, a series of seminars as well as the journals that were present. And as time goes on I’ve become aware of how important it is for doctors to learn about alcohol, I don’t mean those who have a problem themselves, but those who don’t appreciate the implication for the patients and in other words the big job of the Medical Council on Alcohol has been education and it’s important that that should continue. I think probably I’ve said enough for the time being. Was there anything anybody would like to ask me about in the council?

Professor Virginia Berridge
So in your period as Medical Director, what was the major focus?

Peter Abraham
On education, particularly of doctors and this has been mentioned already, but if doctors aren’t properly educated, they don’t actually see the relevance of alcohol in the patients’ problems. Subsequently after leaving the Medical Council on Alcohol, after retiring from the Army, I did also serve in the NHS assessing patients for compulsory admission and a fellow doctor saw this and he diagnosed quite rightly the people we saw had delirium. And he said he should go into a hospital,
he overlooked the fact that he also needed to have Parentrovite, which I had allowed in the MCA. And I believe that patient did. On the other hand a patient of mine I approached a regional advisor to admit him into ... for him to be admitted, because he had been drinking solidly for six weeks and having nothing to eat apart from the odd sandwich and he agreed to take him into his ward, but when the chap saw the casualty officer, he didn’t really see the problem and fortunately as we were leaving, myself and the patient on the trolley, he had a fit, at which time we about turned and went into the hospital that the regional advisor had already agreed to and subsequently had plenty of Parentrovite for several days and did do very well. I’ve seen him a number of times since then and he’s done extremely well, he has actually given up smoking as well, but he only did that about three years ago. So back to education again.

**Professor Virginia Berridge**

Right thank you. Yes I can see a hand over there.

**Dr Guy Ratcliffe**

I was the Medical Director of the MCA in the noughties, so I took over from Peter and I handed over to Dominique so we’ve got, not quite the full set, but certainly the last. Can I just make one or two points about what the speakers made, what they said. First of all can I just clarify that the MCA became the Medical Council on Alcohol in 2002, although when I joined the MCA in 2000 there was talk of changing the name. This was largely due to the fact that we felt that our education covered all aspects of alcohol and not just addiction. More over the MCA was well represented by many specialities, some of who, some people will know the people involved in that. Sadly one of the main issues I faced was the funding issue, but I’m delighted that the links established with OUP have been so fruitful and it sounds good for the future of the MCA. So I’ll say no more on that. In respect to education of medical students, um, the MCA has held an annual essay prize, which I think has been going for probably 25, maybe 30 years and it may be that one option would be to put the winning prizes, the winning essays as a publication, because they would be extremely interesting and they cover jolly nearly every aspect of alcohol in our daily lives. The handbooks that have been mentioned, I think that is the only handbook that anybody produces on the subject of alcohol and I fully support the good news that people have been saying about the handbook and how useful it has been. I don’t know whether there is a new edition being planned, but the last one which I think was published in 2010 did include social aspects, not least driving etc., etc., and I think that was an addition. And certainly talking to the BMA students committee was a fairly major step forward and those links have been, as far as I know, extremely useful and students certainly have the opportunity of having a copy of the handbook. If I can just go back to my previous existence before I, I was in the army for many years and I was the first CO of the Royal Hospital Haslar when it became a dry service in 1996 and certainly during my four years there, it was my duty and I emphasise the word, to take at least one consultant out of clinical practice because of his drinking habits and I’ve done that elsewhere as well. But certainly one who readily admitted he had a problem and I’m glad to say responded to the treatment programme that the psychiatrists were able to offer him, but he was in the possibility of injuring patients for about three to four months. As far as I know after he left the army he continued as a consultant for about 15 years. Finally can I just say that um, working for the MCA was a pleasure, but a pretty steep learning curve as one goes along. There is no doubt that alcohol has enormous insipient risk to nearly all of us in one way or the other and I wish the MCA well in the future. Thank you.

**Professor Virginia Berridge**

Thank you very much. Yes.

**Dr Peter Rice**

I was a consultant psychiatrist in Teesside in Scotland and followed Sir Peter Brunt as Chair of Scottish Health Action on alcohol problems. I guess I’ve just been thinking a bit about the kind of collegiality of the MCA and of the speciality. One thing I have to comment on is Iain Smith, Colin Drummond and I were all in the same year at Medical School at University. We started in 1976, so
that’s one year shorter that Bruce Ritson has been involved in the MCA. He started in 1975, so that’s a good stint. But I think what was brought to mind was a conversation I was having with the head of legal services for a local authority in Scotland, who is responsible for alcohol licensing and he was talking about some research he’d read, it may have been, probably some of Bruce’s work. And he said how come you people all know each other and I thought that is interesting, how come we do all know each other, so I think it’s organisations like the MCA, which I think felt to me to be a very kind of natural association to join and to be part of, because it can be quite an isolated job if you’re the only person in your region or locality. So right from the start of my career that networking and sharing things was very important. I’m surprised that lawyer who was an outward looking interested kind of person didn’t feel he had that in his job. So, I think the MCA has been a very important part of that for me. I was absolutely intrigued by Brian’s comments on the alcohol industry and I’d like to say a bit more about that, I don’t know if we want to do that now or later on, but I’d be happy to do either.

Professor Virginia Berridge
No carry on.

Dr Peter Rice
Of course the Scotch Whisky Association is on people’s minds because of the court case coming up tomorrow. But I have been to some Scotch Whisky Association sponsored research events as a junior doctor at the start and I guess what struck me was how, if you like, the profile of parts of the industry have changed. So, in the old days the manufacturers, particularly the spirit manufacturers were the kind of high-minded patricians of the field and the brewers and the publicans were the ruffians. And in fact that’s almost completely switched around now. If we’re making common cause with any parts of the industry as we do from time to time, it tends to be actually with the brewers and publicans now and it’s the spirit manufacturers who are the ones who are coming to court. It’s the spirit manufacturers who are opposing labelling and other things that the health lobby would like to see and the beer manufacturers are the ones who are supporting it. So I think that’s an interesting switch in the way that the alcohol industry has engaged. I guess the other thing that occurred to me and I think it was a great contribution of Brian’s to mention that historical importance of industry funding, is we now have closer links with the tobacco field in particular and I think it may well be that some of the thinking from the tobacco field has now come into the alcohol field and our relationship with industry has been influenced by that. It’s also of course been influenced by the industry’s behaviour and some of the things they’ve done, essentially you know they’ve drawn the demarcation lines. But that’s as I say there’s I think clearly there seems to me to be quite a big change in the profile that, as I say there are people who would have seen themselves as being the upmarket manufacturers have adopted, have really changed their positions really quite considerably I think over that 25/30 years I’ve been involved in the field

Professor Virginia Berridge
Thank you.

Professor Ilana Crome
I’m Ilana from Keele University. I was introduced to the MCA because I once went to ask Marsha Morgan to help me with something at the Royal Free and she threw up her hands and said I’m so busy writing this handbook for the MCA that I can’t give you any time or any help, which was I think quite Marsha Morgan-ish. But um I mean I think the MCA have provided sustainable education over many years and that is very difficult. Having been involved with the project that Hamid Ghodse started at St George’s ten years ago which was a very ambitious project, extremely well-funded at the time, with every medical school having coordinators and champions and changing the curriculum to include substance problems, not only alcohol, it is very difficult to keep this momentum going without sustainable funding. And of course we don’t know quite how much and whether the education affects patient outcome. That is very difficult to evaluate. But I certainly think it’s impressive that the MCA has continued over such a long time in such a difficult area and with relatively little funding and as Betsy was saying I mean it’s the profile of the people
we want to train that has changed, because we work in teams now. In face I don’t know of many places where patients see consultant psychiatrists so readily because of the dreadful cut in services particularly alcohol services and we’re dealing with a different population of patients. We are dealing with young people under the age of 18 and we’re dealing with old people over the age of 60 or so. So I think there’s a huge amount that still needs to be done, but the problem is to keep that going and to keep the momentum going, because we do need to encourage and stimulate and inspire younger people to take on this, what can be a very challenging, but also a very rewarding career in addiction psychiatry and as Colin said that has really declined and diminished over the last 5/6 years, which is quite tragic when you consider how many more interventions we could implement, but we don’t have the resources of the facilities or staff to do it.

**Professor Virginia Berridge**
Thank you. We’ve spoken a lot about education and treatment, we haven’t said so much about the MCA’s response to policy issues. Does anyone want, have any memories of that or um more recent responses? Has the MCA been involved in commenting on Government policy?

**Dr Guy Ratcliffe**
Well in a nutshell the MCA was one of the founding members of the alcohol advice at the Royal College of Physicians and the MCA, sorry ... Shall I start again?

**Professor Virginia Berridge**
Yes.

**Dr Guy Ratcliffe**
The MCA was one of the founder members of the Alcohol Health Alliance set up by Ian Gilmore at the Royal College of Physicians and the college has been, sorry the MCA has been affiliated to the RCP for probably getting on for 15 years. That was nothing more than a casual link really it didn’t actually mean anything terribly other than the fact that we were able to use some of their facilities should the need arise.

**Professor Virginia Berridge**
Thanks a lot. And I think that brings up the issue too of how we, I’m glad you’ve got your hand up, how it positions itself in relation to other organisations in the field.

**Ms Katherine Brown**
From the Institute of Alcohol Studies. So I just wanted to say that the MCA has been a very active member of the Alcohol Health Alliance in recent years. I’ve been affiliated with the Alliance for the last seven years and I’ve really enjoyed the relationship that I’ve developed with the MCA, with Dominique, with Colin, with Peter and Bruce and I think that the MCA have got a very important role to play with some of the current policy issues that the Alcohol Health Alliance is campaigning on, in particular the promotion of the latest Chief Medical Officers’ drinking guidelines, which the Government have done very little to support the dissemination of information to healthcare professionals. I think this is something that the MCA could help, well both communications members, but also to try to advocate for better information, provision to medical professionals and wider stakeholders as mentioned by Betsy and housing officers, wider public servants that have been identified to deliver brief advice. I also think that the MCA can play an important role in championing the issue around stigma, which we haven’t really talked about a lot today and the issue of providing support to healthcare professionals that themselves have problems with their own drinking habits, in order to help them both deal with these problems, but also to give them the confidence that they can deliver this brief advice to patients. I know there’s an awful lot of attention often awarded to healthcare professionals or members of the NHS who have problems with their weight management, delivering brief interventions to fellow overweight patients, I suppose because it’s a more visible issue, but I think alcohol requires the same volume of attention. I think the MCA is perfectly positioned in order to support that. Then my final point
because I always do points in threes, is that I think the MCA has got a really important role to try and advocate for more funding and support delivered to addiction psychiatry training, because I’m terrified by some of the slides that Colin shows at events whereby you know we’re seeing numbers of trained addiction psychiatrists, more than halving in ten years and I’m not really sure where things are travelling at the moment and I think we need to be assessing the gender and raising awareness of this and speaking to Government and decision makers, to really, really shine a light on this important issue that might have quite dramatic and dire consequences in years to come.

**Professor Virginia Berridge**
Thank you very much. Susanne?

**Professor Susanne MacGregor**
Could I just throw in a question really about the relationship of the MCA to the new large service providers. I mean there’s a tendency to think that treatment and care has disappeared completely, but it hasn’t, it’s shifted over to CGL, Addaction, Turning Point and organisations like that, who are employing healthcare professionals and others and um, including psychiatrists and I just wonder whether perhaps there should be some recognition that at the moment that’s where the action is and that’s where the funding has gone. And to take up the point of where do people who need treatment go – they do actually go into those services which are provided perhaps at the local level. The funding has been cut but it did rise tremendously under New Labour and in the coalition years and more recently there has been more attention to alcohol vis a vis drugs. So it’s not such a completely barren picture but I think it’s a question I’m asking really and throwing, you know perhaps not to be answered now, but whether the Medical Council on Alcohol could play a role in liaising with the big service providers and getting them to take treatment and care seriously. I think that there are people there who would be listening.

**Professor Virginia Berridge**
Interesting point. Yeah, Iain?

**Dr Iain Smith**
We don’t have that particular problem yet in Scotland and hopefully it won’t come, but as an outside observer listening in on the English situation, I’m not aware of medical students, maybe you’ll correct me, of going on placement to some of these teams, but maybe they do. I often hear of people from Public Health England saying well we’ve yet to sort out some of these training aspects of the NHS that traditionally was involved in and maybe part of the reason that these organisations were able to put in a tender that was competitive is because they’ve divested themselves of some of these other traditional tasks that were built into the NHS system. So I think it’s worrying. We should know more as to what’s going on with teaching undergraduate and early postgraduate medical education. It may be lost, I don’t know Colin may have a better insight on that hopefully.

**Professor Colin Drummond**
Well I think the issue is not really with the providers. The 60% of our addiction psychiatrists now work for the third sector and you know they’re just as involved as they ever were. The problem is the commissioning of the services doesn’t include things like capacity for training or you know particularly training junior doctors, but also training medical students. Some of the contracts that have been awarded in England specifically prohibit training of professionals outside of the immediate service. So I don’t take issue with third sector, I take issue with the policy, which drives third sector providers to abandon against perhaps their better judgement or will, training and education and research and all the other things that make this field move forward and re-stock the supply of trained professionals who are going to take over from us in the future.

**Professor Virginia Berridge**
Alan.
**Professor Alan Mayon-Davis**
I’m speaking this time as Chair of Alcohol Research UK/Alcohol Concern. I just wanted to shift the focus a little bit onto research, on the MCA’s role in terms of advocacy for more research. The voice of health professionals is a very powerful voice, much pressure could be brought on the Government and powers that be, in terms of putting more funding into research into the alcohol field. The Association of Medical Royal Colleges, the Royal College of Nursing, other health professional bodies can add their weight, and I think the MCA has to some extent in the past, but can do more in the future to use that strength of opinion and that weight to put pressure on, because there is chronic underfunding of alcohol research. I mean our own organisation came into being, I think it was in 1982 originally as the Alcohol Education and Research Council, the funding for that originally came out of an Act in 1904, a levy on publicans around the country was put into a fund and most of that funding went into setting up the AERC, and then in 2011 the AERC was about to disappear because of the bonfire of the quangos and then out of that we put together the charity which became Alcohol Research UK. And earlier this year in March we merged with Alcohol Concern. Historically our work has been very much in terms of funding, but although we had a reasonably large amount of money, funds put into us at the beginning, the amount of money we can actually invest in research is small, it’s only about half a million pounds a year. So, we are a very small charity and we do rely on the bigger funding agencies to put the big money into research, like the NIHR, MRC, ESRC etc. and some of the bigger charities. So, there is a shortage of funding in research and we would hope that the MCA would continue and perhaps do more to advocate for more investment in research.

**Professor Virginia Berridge**
Thanks very much. Now we’re getting towards the end of our time and I know most people have spoken but there are one or two who haven’t, so I wondered if anyone who hasn’t spoken yet, would like to contribute?

**Dr James Nicholls**
From Alcohol Research UK and also with a link to Virginia’s Centre for History in Public Health at the London School of Hygiene and Tropical Medicine. I’ve been quite happy to just listen mostly, but I’ve had some thoughts throughout. I think my, I was quite interested in the, I mean this shift away from looking at treatment back to looking at treatment, away from looking at treatment, back to looking at treatment and the kind of tensions and why that might be the case and what might be driving that and how you might balance the tensions between a focus on treatment and a focus on more upstream interventions or more upstream policy issues. I wondered the extent to which in that pendulum shifting away from the kind of chronic drinking individual towards the population level issues. The extent to which that was driven by political context and how much that is to do with it. The extent to which it’s been the DHSS’s interest, or the Department of Health’s interest or the Home Office, whoever was interested in it at a departmental level, to what extent it’s to do with funding and changes in funding structures. I was also quite interested in the extent to which it’s also related to a shift in the framing of the alcohol problem within Public Health more broadly, towards a population level conceptualisation of alcohol. I was thinking about maybe the extent to which, what has happened is that what was a very important and legitimate criticism or critique of a very binary medical model of alcohol related harms in the late 1960s and early 1970s, with people like Kettil Bruun and people round that, which made the case that if you simply talk about dependent drinkers and other drinkers then that kind of solves the problem for the industry to an extent, because it says well it’s about the drinker not the drink, which developed then the continuous model of alcohol related harm, which argued well everyone is on a kind of spectrum of alcohol related harm, so we can tackle this at population level, which is an important critique. But whether in focusing on that critique alone you start to, that becomes the salient explanation and moves away from the kind of focus on the treatment side as well and how you balance those two things together. So whether it’s possible at the same time to say, we are interested in population level not interventions, but we also acknowledge that there are very acute problems at the hard end of the issue. I think that’s been a political tension that’s been hard
to resolve actually, partly because it’s recognised that again the alcohol industry, it’s a very convenient argument for the alcohol industry to make the case about high level consumption, but that doesn’t necessarily mean it’s incorrect. It means that there’s a tension there. So I’m quite interested in that and I think in terms of our own history now as the merged organisation, there is something of that there as well. If you think about the history of Alcohol Concern having originally been established you know to really represent the kind of treatment sector, having moved away from that to a much more focus on ... As far as I’m aware and I may be mispronouncing here so if anyone wants to correct me please do, but my understanding is that it was a quite a conscious decision a number of years ago to say oh we’ll focus on the more kind of big ticket upstream policy population level work. This again was very important thing to do and we were very influential in doing that, but whether the treatment sector lost an advocate, or an advocate for the treatment centre became less vocal and maybe that also could be the case across the field in terms of alcohol research and how again we balance that. Again that tension between saying we recognise we need upstream interventions, but we also recognise the need to support and defend treatment, especially in this time of change when I think a lot of people don’t understand what’s going on in those changes, you know the change to the third sector and private providers. Um, yeah so I think that was kind of my main interest. And again speaking with my historian hat on, it’s certainly an issue that goes right back in the history of thinking around alcohol. If you look at the tension in the Temperance Movement between the kind of the reclamation of the drunkard approach and the prohibitionist approach. They were often in tension with each other, they didn’t like each other very much quite often because one was saying we can stop this from happening at all and the other one was saying in a sense the poor will always be with us, the alcoholic will always be with us, but how do we deal with that reality. So I was just very interested in, that we seem to be in a very interesting moment in history now with things like what’s happening with Alcohol Concern, Alcohol Research UK, with the MCA, we’ve reached this milestone with the kind of amazing stuff that’s going on in policy with the IS and the AHA. But it feels to me from the long perspective that this is a moment where there’s a kind of opportunity to look back and say how do those tensions stand right now and how do they, like we’re trying to resolve them right now and how do we move forward having resolved them, in whichever way is appropriate to this moment in history, so that we can achieve the best outcome as possible. So that was my comment.

**Professor Virginia Berridge**

Thank you. Well lots of hands up. Dominique you haven’t spoken yet.

**Dr Dominique Florin, MCA Medical Director**

From the Medical Council on Alcohol and just to put my place in the line of Medical Directors before me, I as Simon said am the first female and also the first one who hasn’t been a member of the armed forces. So that’s been a change.

(Laughing.)

I’m also a GP and there was a question which was possibly Simon who said how many GPs are involved in the MCA now and the answer is apart from me, I think none, which I think is a shame, but reflects a number of the difficulties in being a GP and sharing your time with other activities. One of the problems with being a GP is that you are always told to do more and after this meeting unfortunately that’s also going to be one of the problems for the medical director of the MCA, i.e., me, there’s more we need to do. I’m quite compelled actually by the discussion around treatment and I do think that’s something we could look at again. I’m grateful for what Ilana said that we managed to hang in there on education and that’s taken up most of my time. But I think there is more that we could be thinking about with treatment and that’s something I would like to take forward from this meeting. Around health policy, we’ve got some very active members around the health policy community which is great and under the banner of the MCA, the medical profession concerned with alcohol and I think that works well. I think perhaps what we’ve under discussed today is perhaps about the journal and the impact it’s made, not just
financially, which is undoubted, but in, along the years I think it’s been part of the MCA identity and I feel there’s probably something there about what has this journal that’s been alongside the MCA throughout this time, what has it contributed and just sort of valuing that I think. So I mean, I don’t know if Allan Thomson has got more to say about that or indeed anybody else.

Professor Virginia Berridge
Yeah. No I think, I don’t know if Allan if you want to say anything, or Jane, both of you I think would have things to...

Dr Irene Guerrini
I’m a consultant lead psychiatrist in addiction for South London Maudsley NHS Trust. So the first time I encountered the lovely red journal was at the very, very end of the 80s when as a young trainee I had a very strong interest at the time, in alcohol dependence. So I wrote with my mentor, a little clinical article about, yeah some clinical aspect of alcohol dependence. We were puzzled where to send these papers. I was back in Italy so at the time we have very limited resources, very limited access to library. So my mentor said well there is a very lovely journal, it’s called Alcohol and Alcoholism, it’s quite a wide audience, so you can publish papers on research papers, clinical treatment, policy and blah, blah. So I said okay and I submitted this paper. Unfortunately it was rejected, but I got a very lovely letter from the editor, which was Allan and I still have the letter, yes. The strange story was that I met Allan again in 2000 when I was at UCL doing my project in WKS and a few years later I become part of the MCA journal committee as a member. So for me it was a great honour, coming from as I say, from the 80s where the journal was something that was quite amazing. I think the journal has contributed a lot to the visibility of the MCA and for me it’s always been an honour to be part of the committee and through the years actually the impact factor has grown significantly. There’s been more interest in publishing papers from the States, we got now you know a represent, an editor based in the States that has increased the visibility of the journal over the ocean. So I think the journal has moved a lot and it has also had quite a big impact financially on the sustainability of the Medical Council. So thank you.

Professor Virginia Berridge
Thanks very much. Would either of you like to say more about the journal. No? Alan?

Dr Allan Thomson
Maybe I could say a few words, I think the journal has contributed in some ways in which it’s not obvious. I mean clearly it has contributed by presenting research at all different levels from identifying the extent of the problem, to looking at different treatment facilities and to try to understand at a fundamental level what is happening in these patients. But I think in a way it’s given a lot of life to the MCA itself. The journal has now been going for 50 years in one form or another and it is, the journal itself has benefitted greatly from the input of many capable and distinguished people, who have been either on the editorial team, or overseas editors, editorial advisory board or MCA members. And I think this has fed into the life of the Medical Council and I think that the journal has probably provided the MCA with a national and eventually an international platform for promoting its views and ideas. And it’s given members of the MCA the opportunity to gain experience in editing, publishing and reviewing the papers and I think has stimulated research in this country. So I think that has been helpful. Um and eventually it has been able to contribute significantly to the survival of the Medical Council, which was very different, going back to 1980 when I was subjected to considerable discussion for an hour and a half or so by the executive committee as to why I thought the journal might succeed and why should they support it and so on and so forth. But here we are.

Professor Virginia Berridge
Thanks. Jane did you want to add?
Dr Jane Marshall
I think Allan has said ...

Professor Virginia Berridge
Okay. Well I think we are nearly at an end, our closing point. I just wondered whether our other speakers wanted to make any further comments in the light of what they’ve heard. Bruce did you want to say anymore?

Dr Bruce Ritson
I think it’s been an excellent discussion and I think as Dominique has just said it points all sorts of directions we should be moving in. We’ve talked about the reframing of views about alcohol and I think that’s run through a lot of what I experienced over the years. But it started off very much as an individual problem of the drinker and in response to research and other changes, it got completely re-framed, the problem, perhaps too completely reframed from what we’re saying, to rightly being seen as of course an important issue lying with alcohol itself and possibly the industry is less interested in funding us as we changed our views. That did cross my mind, because really in the early days of funding it wasn’t, maybe I’m speaking ... on the part of the MCA, it wasn’t really seen as an issue. But it rapidly became seen as an issue when the focus moved to the drug/alcohol. We wrote, the College of Psychiatrists wrote a piece called ‘Alcohol and our favourite drug’ which called a lot of upset in the industry, because they didn’t want it to be seen as a drug like others. So I think we’ve experienced a big change in attitudes in the medical profession. But it has still the problems we had at the start, are still there of requiring adequate services to help people with serious alcohol problems and this discussion has brought that very much to the fore and I’m pleased about that. I’m very encouraged now for the future as long as we can, I suppose be an advocate, it’s hard to know what more we can do than advocate for the importance of treatment services. Of course the journal helps here by providing the research basic ammunition for this, but the need for services anecdotaly is very apparent.

Professor Virginia Berridge
Thank you. Brian did you want to say something?

Dr Brian Hore
I would like to emphasise the fact that the Medical Council did go on because for meeting after meeting it was quite depressing. We were told we had enough funding for two years, one year, six months. It got very close, but somehow people remained convinced that it was worth plodding on, even though there was no guarantee long term and negotiating in a way which we never thought about in relation to the journal. We couldn’t see any end of this shortage of money, we thought it would close. But it still kept going. I think certainly two out of three of the other bodies, did close, maybe three out of three and this was the only one that kept going. But it needed quite a bit of faith to believe it could work. I think Allan would agree with me there.

Professor Virginia Berridge
Colin?

Professor Colin Drummond
Just to repeat Bruce’s comment I think this has been a really useful afternoon and it will be really good to see this kind of written up and actually reflect on what’s come out of it and feed that into our thinking of what we should be doing going forward. This issue of advocacy is a tricky one, I mean I don’t personally see a conflict between on the one hand advocating for you know unit pricing and more brief interventions in primary care, whilst at the same time having adequate treatment services for people with severe alcohol dependency. But very often the debate gets polarised into you have to do one thing or the other, whereas I think you have to do all of the above and you know part of our role I think is in reframing it, so it doesn’t look like a polarised debate and also to acknowledge that treatment has changed from the concepts that were around in 1967, you know. The base has broadened, the type of clinicians that are involved in delivering
the care to people with alcohol problems has broadened, more gastroenterologists, more GPs and that’s all great, but we don’t want to sort of neglect the needs of the most vulnerable.

**Professor Virginia Berridge**

Thank you very much. Well thanks to everyone for their participation. I think it’s been a very interesting afternoon and as a historian, I’m very pleased that we’ve not only talked about the past, we’ve talked about the past in interesting ways, but also in ways that give pointers for the future and which give food for thought about future developments and future things, ways in which the council might position itself. So I think it’s been a very fruitful afternoon and I look forward to reading the transcript when it comes and that will appear on the MCA website and we’re hoping to do a publication also for the journal from this afternoon. So thank you everyone for participating. And I think now, is there a cup of tea? Yes. Also if people would like to look at the exhibition at the back. Thomas Bewley who was one of the first members of the Medical Council Committee couldn’t be with us today but he has sent some characteristically lively reminiscences which are up on a board over there and there’s also some extracts from the minutes and other papers of the council, which has very usefully kept its archives in good order. So yes. And could I also thank Dominique and Clare for all the work that they’ve put into organising this.

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