institutions with defined workloads and measurable outcomes, but they fit poorly with relationships in which needs change dramatically and continuity is important. The type of commitment required here is much more like a covenant, a promise made which has the fuzzy boundaries necessary for doctors' multitudinous roles.[3] Contracts risk remaining locked into the negative aspects of obligation and of minimal expectation; an explicit but broader two way commitment can develop the positive aspects of care and re-empowerment of everyone involved.

How can this fit with the expressed commitment of health service managers to deliver high quality service? Performance indicators may be of limited use.[4] In particular, they do not value the richness or variety of responses that professionals can offer. The tasks in health care are demanding, and healthcare workers need support on an individual or group basis. It is unclear where this support is coming from in today's NHS. It may be that re-evaluating roles and responsibilities within the new healthcare team will result in perceived loss. This must be balanced by potential gain, which an environment of "coercive healthism"—where the government's role of health protection is confused with the profession's role of health promotion—has not yet shown.[5]

When loyalty and commitment are challenged or broken, people feel betrayed. The reaction of many doctors to the uncomfortable process of setting new boundaries has been enormous hurt. This feeling has been expressed by resisting further change, low morale, endless moaning, a rise in the prevalance of stress, and evidence of burnout.

Understandably younger doctors have become increasingly reluctant to sign up for some career paths. This reassessment of what sort of job is worth doing is not confined to medicine: decline in trust and loyalty has been recognised in a variety of work environments.[6] Doctors should be able to see medical work in transactional terms without losing their sense of vocation, and young doctors have something to teach their elders about keeping the patients central to their work while creating healthy boundaries between personal and professional life.

The NHS has received enormous loyalty from staff and patients. Whereas loyalty is based in the past, commitment looks to the future and is a conscious choice. Commitment must express what sort of people we want to be as well as what things it seems worth while to do. Although as doctors we are taught to take a good history from patients, our own histories often remain hidden from us. Hitherto we have not needed to be clear about our personal and professional needs and aims, but now we must recognise and explain what lies deeper than current economic or political fashion, and to make our goals explicit. As in Hirschmann's influential challenge to current market orthodoxy, in place of the prevailing culture of "exit" (leaving, closing down, or merging) we need to find our own loyal "voice" to criticise and improve the system while remaining within it.[7]

Balancing act

Yet a newly skilled and articulate generation will not eliminate the inevitable conflict between different spheres and types of commitment—home or work, patients or paperwork. A promise to give more to one implies a decision to give less to the other. A new task requires new time. The balance of competing commitments requires constant attention and adjustment to ensure the best use of scarce personal resources, including professional enthusiasm, constructive attention, and appropriate compassion. Such resources can be properly understood only in the context of a clear tradition,[8] and doctors need the confidence to respect and defend their tradition to set the proper boundaries for a "do-able" job. Only if we value the diversity, energy, and creativity inherent in medical work are we likely to be able to ensure that our commitment flourishes and is transmitted to future generations.

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The war on drugs

Prohibition isn't working—some legalisation will help

Drugs, says psychiatrist Thomas Szasz, have taken over the lead role from sex in the "the grand morality play of human existence."[1] "No longer," says Szasz, "are men, women, and children tempted, corrupted, and ruined by the irresistibly sweet pleasures of sex; instead, they are tempted, corrupted, and ruined by the irresistibly sweet pleasures of drugs." Because dealing with drugs is viewed as a moral problem, politicians tend to compete in their zeal to banish the evil from the kingdom. Those who talk of legalisation are dismissed as mavericks, and whipped back into line. The British government's drug strategy for the next three years states baldly "There will be no legalisation of any currently controlled drugs."[2] But some legalisation would help.

The politicians fighting the jihad against drugs want to obliterate the enemy. They, of course, make an exception for legal drugs like alcohol, nicotine, and caffeine; indeed, the British government last week recommended tee totallers to take up drinking alcohol for the good of their health.[3] Yet a world devoid of drugs seems as unlikely as a world devoid of poverty and sin. Thomas Sydenham observed 300 years ago that "Among the remedies which it has pleased Almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium" (4); and Aldous Huxley wrote "That humanity at large will ever be able to dispense with Artificial Paradises seems very unlikely. Most men and women lead lives at the worst so painful, at the best so monotonous, poor and limited that the urge to escape, the longing to transcend themselves if only for a few moments, is and has always been one of the principal appetites of the soul."[5]

If we accept that a world without drugs is unachievable (and probably intolerable) then the important question, argues drug policy expert Ethan Nadelmann, becomes "What are the best means to regulate the production, distribution and consumption of the great variety of psychoactive substances available today and in the foreseeable future?"[6] To reduce the debate to arguments between "prohibitionists" and "legalisers" is to oversimplify, but it's a useful device for beginning to understand the issues.

The case for legalising drugs begins with the failure of current prohibitionist policies. The United States has been conducting a "war on drugs" for seven decades, during which time there have been steady increases in seizures of illegal drugs, the numbers of people using drugs, and the health and social costs of drug taking. Economists argue from first principles that the war on drugs must fail. Any success in reducing the supply will raise the price of illegal drugs. Addicts must then commit more crime to feed their habit; and a rise in the profit margins of drug smugglers urges them on to greater efforts.

The history of the drug trade is that supply always meets demand. Milton Friedman, the Nobel prize winning economist, puts it thus: "Illegality creates obscene profits that finance the murderous tactics of the drug lords; illegality leads to the corruption of law enforcement officials; illegality monopolises the efforts of honest law forces so that they are starved of resources to fight the simpler crimes of robbery, theft and assault."[7] The main result of the United States war on drugs is a prison system bursting with petty drug offenders, most of them African-Americans.

Britain has never been as warlike as the United States in its efforts to control drugs. British policy is, however, essentially prohibitionist, and yet about seven million people in Britain have taken cannabis at some time in their lives.[8] About a quarter to a third of young people have tried solvents or illegal drugs by their 20th birthday[9], and in one survey the proportion of young people who had been offered drugs rose from 2% in 1969 to 41% in 1994.[9] LSD and ecstasy have now also been absorbed into mainstream youth culture, with about 9% of those aged 16 to 19 having used ecstasy and about 8% LSD.[8] These high reported prevalences are likely to be true because seizures of cannabis more than tripled from 23 592 in 1984 to 107 629 in 1994, ecstasy seizures increased from 39 in 1989 to 715 in 1994, and heroin seizures rose from 2995 in 1984 to 4480 in 1994.[10]

Time to consider going Dutch?

Other countries have been more willing to experiment with decriminalisation and legalisation. The Netherlands effectively decriminalised personal possession of drugs in 1976, and cannabis is sold in "coffee shops." The Dutch are now coming under great pressure to reverse their experiment from neighbouring countries, worried that they are being flooded with drugs from the Netherlands. Yet the 1976 changes in the Netherlands seem to have been followed by a fall in use of cannabis: from 13% of those aged 17-18 in 1976 to 6% in 1985.[11] Monthly prevalence of cannabis use among Dutch high school students is around 5·4% compared with 29% in the United States.[11] Forbidden fruit may, indeed, be sweetest.

One simple argument for decriminalising drugs is often used by governments in the context of tobacco: that the state has no right to interfere with what individuals do in private so long as they don't harm others. Another argument is that legalisation would cut the huge costs of enforcement, prosecution, and imprisonment. Thirdly, a legal market could allow quality control of the drugs and education on how to avoid them or use them more safely; drugs might more predictably be prevented from reaching the young and vulnerable. Finally, many of the adverse health effects of drugs stem from criminalisation rather than from the drugs themselves. Anyway, current policy is clearly not driven by totting up the good and bad effects of drugs: few are more harmful than tobacco.

Although, the arguments for legalisation can be expressed forcefully, almost nobody argues for a free, legal, unregulated market for all drugs, and clearly no single policy will cover all drugs. Nadelmann says: "It is imperative that any drug policy distinguishes between casual use that results in little or no harm to anyone, drug misuse that causes harm primarily to the consumer, and drug misuse that results in palpable harm to others—and then focuses primarily on the last of these, secondarily on preventing the misuse of drugs, and little at all on casual drug use."[6]

The key question is how the world would look if drugs were legal. The Australian National Task Force on Cannabis has identified five options for cannabis legislation: total prohibition; prohibition with civil penalties; partial prohibition; regulation of the production, distribution, and sale of cannabis; and free availability.[12] The task force opted for keeping possession, cultivation, and sale in any quantity illegal but decriminalising "simple personal use or possession . . . without compromising activities aimed at deterring cannabis use." Others—for instance, economist Richard Stevenson—have tried to describe a world where large companies produce, distribute, and advertise drugs like heroin and cocaine and invest heavily in research designed to produce drugs that will satisfy customers' wants while making them safer.[13]

Much more work needs to be done on envisaging a world that includes some legalisation of drugs. But it's clear that purely prohibitionist policies don't work and make the problems of drug abuse worse.

Governments worldwide have followed illogical and often counterproductive drug policies, primarily because drug use is seen in moral terms. Wars on drugs are doomed to failure, but experiments with decriminalising and even legalising drugs—as in the Netherlands—have shown promising results. Policies that allow some decriminalisation and legalisation are much more likely than prohibition to succeed in achieving everybody's aim of minimising the harm from drug abuse.

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