

they know that many of their other patients are dependent on opiates, the only difference being that the dependence has not been diagnosed. Once the dependence is identified, the patient is treated with disdain. It is poor medical practice not to treat opiate dependence, when methadone is available and might be indicated.

A full and comprehensive assessment goes a long way to clarifying the nature of a patient's needs. In Ontario, Canada, addiction medicine specialists have the luxury of devoting as much time as they need to interviews with drug-dependent patients. Manipulative, offensive and uncommitted patients can be excluded by screening. Asking patients to sign a contract with the physician enables sanctions to be imposed should patients violate the rules of a methadone maintenance programme. The most effective sanction is the loss of 'carry privileges', that is, patients who are not showing signs of total commitment to abstinence during recovery are obliged to obtain their methadone on a daily basis at a pharmacy. This encourages compliance.

Physicians in Ontario have professional freedom to prescribe whatever dose of methadone is required to eliminate withdrawal symptoms and cravings in an opiate-dependent patient. The vast majority of patients, therefore, take 80 mg to 140 mg of methadone daily. From personal experience, I would warn physicians against initiating medication at a dose of 40 mg daily. This dose has been associated with fatalities (anecdotal evidence from the Bureau of Drug Surveillance, Health and Welfare, Canada). It is more prudent to start treatment at 20 mg daily, increasing the dose by 5 mg every three or four days.

When I was a general practitioner, I offered both general medical care and methadone prescribing to the same patient. This proved to be demanding and cumbersome and led to opiate-dependent patients seeking medication for many self-limiting ailments. As a result, keeping methadone prescribing in a separate and distinct practice has seemingly reduced the polypharmacy that previously existed when dealing with opiate-dependent patients.

At present, as an addiction specialist, I see 50 patients on methadone maintenance programmes in clinics twice a week, each clinic running for approximately five hours. Of these patients, 95% are abstinent, at least their witnessed samples of urine are negative, and many have returned to work, been reconciled with their families or remained 'off the street'.

Working with opiate-dependent patients can be satisfying and rewarding.

Recovery is one of the hardest things any patient can achieve; it is enjoyable to facilitate and participate in that process. More physicians and, in turn, medical students should be encouraged to increase their knowledge and expertise in this small subspecialty of medicine. In Ontario there are signs that the appropriate changes, which are long overdue, are starting to appear.

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### Bereavement care

Sir,

As suggested by Charlton and Dolman in their discussion paper proposing a bereavement protocol for primary care (*August Journal*, p.427), anything that encourages people 'to understand and be available'<sup>1</sup> to bereaved people must be welcomed. Developing bereavement protocols in primary care is perhaps the most effective way of ensuring that the primary care team does not turn its back on its bereaved patients. It is important to include patients who are suddenly and unexpectedly bereaved, and therefore having a protocol that starts immediately after a death makes sense. But in the majority of cases, where death is preceded by a terminal illness, there will be advantages in starting the protocol earlier. As Charlton and Dolman acknowledge, the process of grieving has already begun.

As well as helping a terminally ill patient achieve the best possible death, good terminal care involves supporting the patient's carers. This includes acknowledging their psychological distress and recognizing that the majority will suffer symptoms such as anxiety, insomnia and weight loss.<sup>2</sup> Bereavement care should follow naturally from good terminal care.

A bereavement protocol needs to define who is bereaved. With the increasing loosening of traditional family ties it is often unclear who constitutes a person's family. The person who knows this best is the person who is dying and it seems sensible to ask the patient who will need bereavement care. It is not a difficult question to ask a patient who accepts that

he or she is terminally ill and who will almost certainly be comforted to know that loved ones will be cared for. This simple question allows us to enlarge the circle of legitimate grievers and recognize the importance of what Doka has called disenfranchised grievers;<sup>3</sup> 'those with no socially recognized right, role or capacity to grieve', for example lovers, friends and people with learning disability. They too need good bereavement care.

Clear guidelines about how to identify people at risk of developing pathological grief need to be incorporated into the protocol. Once such risk factors are identified it is important that bereaved people are followed up over at least two years and questioned sensitively about their mental state. This should be the responsibility of the primary health care team. If this process is not followed there is a danger that the primary health care team's acknowledgement of loss and grief will be superseded by therapeutic paralysis in the face of developing depression.

The National Association of Bereavement Services, 20 Norton Folgate, London E1 6DB (telephone: 0171 247 1080) provides a useful, comprehensive directory of bereavement services and can put patients in touch with the most appropriate bereavement organizations in their area. The association covers diverse groups offering support for people of different race, religion, sexuality and age and for different kinds of illness or loss.

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Sir,

We were interested to read the helpful discussion paper by Charlton and Dolman on a bereavement protocol for primary care (*August Journal*, p.427). They are right to highlight the potential role of primary care professionals in the prevention of dam-

aging grief reactions among patients. To this end the protocol has much to commend it. General practitioners will find many of the suggestions appealing and may wish to incorporate them into their own guidelines.

Before we adopt such a policy unreservedly, however, it is important to consider the dangers of overmedicalizing grief. Grief can be considered a normal part of ageing.<sup>1</sup> The more the medical profession become involved in bereavement, the more it takes on the connotations of a disease.<sup>2</sup> The resulting medical responsibility could have sociolegal consequences. It may, for example, weaken patients' existing supportive social constructs. This could have implications beyond the immediate bereavement, as society learns a new model for coping. On an individual level, it could also limit the person's emotional growth that can come from grief.<sup>3</sup>

Given these concerns, it is imperative that any future protocol has clearly defined benefits. This is achievable, given the evidence for bereavement counselling, although we must remember that this research has been based in non-primary care settings.<sup>4</sup> Also, in order to facilitate successful counselling, there is an advantage in planning care according to a risk assessment. This can be performed by applying forms used in hospices.<sup>5</sup> There may be some benefit from delaying this assessment until the rituals of death are complete, when the bereaved patient's true vulnerability may be more apparent.

An additional concern relates to applying a uniform approach to what is a highly individualized, complex psychological phenomenon. A bereavement protocol has to respect this by being versatile. The protocol suggested by Charlton and Dolman allows the general practitioner an individually tailored response to a bereaved person. However, it should also ensure that it fully complements existing professional and social care. A combination of a risk assessment and an awareness of all the follow-up options will facilitate appropriate intervention. Such an approach perhaps needs to be incorporated into the protocol. This desire for versatility needs to be considered for any written material used. Care needs to be taken in its preparation and piloting, as this information must be presented in a form helpful to the general public.

Grief has considerable health implications that require the attention of primary care. However, any approach to the problem of such implications has to have clear benefits and be sensitive to the social context of bereavement. In order to answer these anxieties there is a need to expand

the limited research into bereavement and bereavement support in primary care, particularly in the evaluation of any proposed innovations.

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Sir,

The paper by Charlton and Dolman discussing the use of a bereavement protocol in primary care (*August Journal*, p.427) appears to omit one important date of contact between a general practitioner and his or her bereaved patient. This is between six and eight weeks after the event, when the relatives, counsellors and others have gone their way and the bereaved person is having to face life as it really is, alone. This date has the added merit of being one by which psychotic depression, as opposed to justifiable misery, is relatively obvious, relatively common, but entirely treatable.

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### GP-patient social and sexual contact

Sir,

I was interested in the article by Coverdale and colleagues on social and sexual contact between general practitioners and patients (*May Journal*, p.245) because of its importance and because I was one of the doctors who replied to the questionnaire. Two aspects of the study are open to criticism.

No distinction was made between general practitioners working in rural and urban areas, between single and married general practitioners and between single and married patients. There is a vast difference between a single general practitioner working in a rural area who has to suture a cut finger of a young woman patient whom he then meets socially in the community (they are attracted and marry or become lovers); and a married general practitioner working in a city who seduces a patient who has attended him for counselling about an unsatisfactory marriage. More useful information could have been gained from the study if general practitioners had been asked to judge perhaps six such scenarios.

The other criticism is that there was no way of distinguishing how the general practitioner respondents in the study had learned about sexual contacts between other general practitioners and patients and whether reported cases were public knowledge. The three cases known to me were general practitioners whom I knew personally and whose names had been published in the *New Zealand Medical Journal*.

I hope that this important study is not taken as a baseline against which to measure any future changes but that it is considered as a pilot study from which comes further work on what many would see as one of the most serious breaches of trust between doctors and their patients.

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### Complementary medicine

Sir,

I would like to comment on the letter from Ernst and colleagues (*September Journal*, p.506) which gave a definition of complementary medicine. Many doctors besides me must have long been puzzled by the need for such a definition. A definition of complementary medicine would be unnecessary if the discipline of medicine itself were properly defined as 'the study of human ailments and of the methods employed for their prevention and treatment'. All ailments, preventive strategies, diagnostic procedures and treatments must then be subject to the scrutiny of the one inclusive discipline. All effective preventive strategies, diagnostic procedures and treatments are subjects of medicine and