practitioner drug services and their lack of success may have been too pessimistic.

The primary care drug dependency centre in Birkenhead provides holistic, client centred, multisectoral, stepwise withdrawal programmes for Wirral residents on behalf of their general practitioners. Chaotic drug abusers, treated as outpatients, are stabilized by the clinical director (who is a general practitioner) and a team drawn from community health and social care organizations. Once stabilized, the clients are transferred back to care by their own general practitioners, aided by support from drug workers (community psychiatric nurses, youth workers or counsellors). If the clients are troublesome, uncooperative or become unstable they are taken back into the centre again, or have treatment withheld until they are again ready to cooperate. A patient would expect to be on the programme for about 18 months.

This service is not costly. At less than £1000 per client per annum for the health and social care provided, it compares favourably with competing psychiatric clinic quotes of over £3000 (Bundred P, personal communication). The clients cared for in supported general practices are less expensive, with only the marginal costs of methadone prescribing and fortnightly drug worker sessions to be met.

This service is successful by a number of measures. The Wirral enjoys one of the lowest rates of human immunodeficiency virus (HIV) infection among notified injectors while suffering the highest prevalence of injected drug abuse in the country.[1] The acquisitive crime rate in the Wirral has dropped by 30% against a national rise of 15% (annual crime statistics report, Merseyside police, 1991/92). Surveys conducted by independent psychologists show that 70% of both clients and referrers are satisfied that the service addresses most or all of their needs satisfactorily.[2] Abuse of the system by those on methadone withdrawal is minimal.

Our experience would suggest that general practitioners working in a primary care setting can be the most cost effective and appropriate agency to care for heroin addiction, provided that a modest investment in human resource support is made.

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Unrecognized ovarian failure after hysterectomy

Sir,

From the letter by Lindsay and Usher (December *Journal*, p.529) and other recent reports,[1,2] it would appear that approximately 72 out of 1000 patients aged 32 to 50 years have had a hysterectomy and that 25 out of 1000 have premature ovarian failure (resulting from bilateral oophorectomy or the fact that hysterectomy advances the age of menopause by up to four years by an unclear mechanism) and 32% of those are not receiving hormone replacement therapy. They would be advised to do so as they are at significantly increased risk of myocardial infarction, stroke and osteoporosis.[3] In future, counselling at the time of hysterectomy may alert women to the need to be aware of the potential problems, but what of those who have already had a hysterectomy?

In October 1992 a computer search of the records of 9100 patients in one general practice revealed 101 women under 50 years old who had had a hysterectomy, of whom 19 were receiving hormone replacement therapy. The 82 non-hormone replacement therapy users were sent a letter inviting them to a group meeting at the surgery where myself and a medical colleague introduced them to the concept and recognition of premature menopause, its problems, its management with hormone replacement therapy and the availability of blood testing for those unsure of their status.

Of those invited 61 attended (74%); subsequently 23 had individual hormone replacement therapy counselling and/or a blood test. Two months after the meeting 14 women who were prematurely menopausal (follicle stimulating hormone level greater than 20 IU l^{-1}, or had menopausal symptoms) started on hormone replacement therapy with its long term beneficial effects.[4] The other women have been alerted to the problems and have been offered a yearly follicle stimulating hormone level test.

The use of the surgery and doctors' time for the group counselling and the expense of the letters of invitation seems justified if a group of women have been identified and have started treatment for this hitherto poorly recognized complication of hysterectomy. Readers may like to consider a similar approach.

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Euthanasia and assisted suicide

Sir,

Irwin Nazareth's digest item (January *Journal*, p.42) on van der Wal and colleagues' articles on euthanasia and assisted suicide in the Netherlands is misleading in one respect, and should be corrected.

Nazareth states that they identified a sample of 1042 Dutch family doctors and found that 'euthanasia or assisted suicide was practised about 2000 times every year by this sample'. This figure is about six times too high. What van der Wal and colleagues actually suggested, extrapolating from the 1042 questionnaires they sent out, was an estimated incidence of 2000 cases per annum for the whole population of Dutch family doctors, a total of about 6300 practitioners. Their result is therefore similar to the study of van der Maas and colleagues which reported that 62% of general practitioners had 'ever performed' euthanasia or assisted suicide, and that 28% had done so within the previous 24 months.[1]

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Medical certification

Sir,

As a doctor working in the 'bureaucratic system' referred to by Dr Toon (November *Journal*, p.486), but having many years' experience of general practice, as have many of my colleagues, I can assure him that we are well aware of the problems of personal physicians, who are also gatekeepers to some state benefits. We do not have a 'naive faith in the objectivity and reliability of medial judgements' in the context of certification, but we do