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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References

1. Seymour H (ed). *Drug use and AIDS/HIV: policy in Mersey region.* Liverpool: Mersey Regional Health Authority, 1992.
2. Withers J. *Wirral community drug team: questionnare survey.* Chester: Chester and Ellesmere Port Psychology Service, 1991.

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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References

1. Siddle N, Sarrel P, Whitehead M. The effect of hysterectomy on the age of ovarian failure: identification of a subgroup of women with premature loss of ovarian function and literature review. *Fertil Steril* 1987; **47:** 94-100.
2. Seeley T. Oestrogen replacement therapy after hysterectomy. *BMJ* 1992; **305:** 811-812.
3. Henderson BE, Paganini-Hill A, Ross RK. Decreased mortality of users of oestrogen replacement therapy. *Arch Intern Med* 1991; **151:** 75-78.
4. Whitehead M, Godfree V. *Hormone replacement therapy. Your questions answered.* Edinburgh: Churchill Livingstone, 1992.

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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Reference

1. Van der Maas PJ, van der Velden JJM, Pijnenborg L, Looman CWN. Euthanasia and other medical decisions concerning the end of life. *Lancet* 1991; **338:** 669-674.

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

have a responsibility to ensure that benefits are paid in accordance with the law. The law requires medical certification and, as Dr Toon rightly points out, such certification for social security purposes is part of a general practitioner's terms and conditions of service.

I believe that a general practitioner's certificate, backed up where appropriate by the Benefits Agency's medical reference service, is a cost effective way of ensuring fair payments of sickness benefits. Where general practitioners have a conflict between the need to give an opinion and their doctor–patient relationship a confidential reference on form RM7 would lead to an examination by a disinterested doctor. Sadly this reference is not used as often as it might be: some general practitioners may prefer to continue to issue certificates in which they may have little faith in order to maintain the doctor–patient relationship.

I note that Dr Toon makes no reference to the statement to be completed by the patient's doctor (or other professional carer) on form DLA1 (part of the patient's claim for the new disability living allowance; a similar statement appears on form DS2 for attendance allowance). The statement requires no opinion from doctors completing it, nor are they expected to verify the patient's assessment of his or her disablement. It is simply a statement of the patient's main disabling condition. Doctors can, however, give any additional information they think may be important. It is then for the adjudication authorities to decide whether sufficient evidence is provided on the claim form. Where more information is required the adjudication officer can seek advice from the Benefits Agency medical staff, and/or other sources, including the patient's general practitioner in the form of a factual report (for which a fee is payable). Clearly the Department of Social Security has a responsibility to safeguard public funds and control machinery has been set up to guard against abuse of the system.

Doctors working for the Benefits Agency Medical Services would welcome 'clearly defined factual information', particularly on form RM2. Unfortunately, they are often expected to advise on such information as 'backache' or 'painful leg'. A properly completed form RM2 will frequently avoid the summoning of sick or disabled people for unnecessary examinations, while at the same time securing another opinion, from the reference service, on those who are fit to attend for examination and may be capable of some work.

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Postgraduate education

Sir,

On reading the paper by Murray and colleagues about a centrally organized scheme for postgraduate education (January *Journal*, p.19) I searched in vain for a suggestion that this scheme was better educationally. The study shows that the attendance at educational sessions of those general practitioners who join the scheme was better than those who do not subscribe. The authors go on to equate 'educational attainment' with number of sessions attended. However, education is a process whereby new skills are acquired together with knowledge and/or attitudes which improve your work.

The authors state that general practitioners must have adequate education to achieve what is required of them with respect to health promotion. I take a contrary view. Most general practitioners already know a lot more about health promotion than they have the time to apply.

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Undergraduate medical education

Sir,

Having read the editorial by Knox (December *Journal*, p.499) I would like to set the record straight. While Dick Scott was pioneering general practitioner teaching in Edinburgh, a group of four general practitioners in Manchester in 1956 started teaching medical students in Darbishire House, the new university health centre. This was long before Pat Byrne arrived as professor of general practice on the recommendation of Robert Platt. He arrived when three of the four original teachers retired and one of them, Dr Davie is now aged 90 years. Dick Scott, Stephen Taylor and John Stopford encouraged the general practitioners in their work at a time when doctors were afraid of taking students into their practice in case it interfered with the doctor–patient relationship and took too much time.

As the youngest of the four Manchester general practitioners I taught until 1986, and over a period of 30 years I hardly took a surgery without a pre- or post-graduate student being present.

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Outcome of the national health process

Sir,

Many people who have been patients of general practitioners or hospital doctors feel that they have been participants in, not a national health service, but a national health process. 'The doctor just ordered tests', 'didn't understand' or 'said just continue the tablets'. Such commonplace observations testify to the impersonal stamp impressed upon some patients. A typical explanation of this circumstance is that there are too few doctors for too many patients and so a process, rather than a service, is quicker and inevitable. In fact, the origin of the processing of patients lies less in their abundance and more in the deficiencies of medical training.

The alpha and omega of medical training is to instil the importance of chasing a named diagnosis and then to arrange treatment. Diagnosis is the doctor's reward, and treatment follows automatically. Medical ethos does not include the pertinaceous questioning of medical outcome. Although current training alludes to consideration of the whole patient, students or doctors fail their examinations for missing a clinical sign or diagnosis or citing inappropriate treatment. They do not fail for omitting to ask: Is the patient benefiting from medical intervention? Is the patient being made worse?

In medical emergencies little else but diagnosis and treatment is germane, and outcome, usually following hard upon treatment, is quickly evident. It is to emergencies, perhaps, that medical training is tailored. But much practice, especially general practice, does not comprise emergencies, and treatment and outcome are often connected not by minutes or hours but, in for example psychological or arthritic conditions, by days or weeks. Also, Pickering's law states that the more treatments there are for a condition the less certainty there is one of them will work. Uncertainty about the benefit of several prospective treatments demands that outcome be energetically sought, so that ineffective treatments be stopped or altered.

In some ways, the diagnosis and treatment are the easy part of medicine and the real challenge is to determine whether the