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Folic acid in pregnancy

Sir,
In December 1992 the Chief Medical Officer issued recommendations on folic acid supplements for pregnant women and women planning pregnancy to help prevent neural tube defects.[1] A disappointingly low level of awareness of these recommendations has been found among women attending hospital antenatal clinics.[2,3] There is little information available about awareness among non-pregnant women. As an estimated 50% of pregnancies are unplanned[4] and many women plan a pregnancy without first seeking medical advice, it seems useful to address the extent of knowledge in this group.

A study was carried out in 1994 in a general practice in west London examining the extent of awareness of the folic acid recommendations among women of childbearing age. A notice in the waiting room asked all women aged 16 to 45 years attending the practice during a three-month period to complete a questionnaire on the use of folic acid and vitamin and mineral supplements in pregnancy.

Completed questionnaires were received from 107 women (mean age 31 years), of whom 95% were Caucasian, 3% Asian and 2% Afro-Caribbean. Fifty one women (48%) were aware of the need for folic acid in pregnancy, 82% of whom correctly stated that supplements should be taken before conception. Three of the nine women planning a pregnancy were aware of the need for folic acid, seven of the 14 women who were currently pregnant had taken folic acid before conception and eight of the nine women who had been pregnant in the previous year were aware of the folic acid recommendations.

Fifty one women (48%) stated that supplements other than folic acid should be taken routinely (iron was listed by 48 women and five vitamins were listed by one woman). Thirty four of the women (32%) were aware of possible harm caused by excessive consumption of vitamin A.[5]

Women's magazines were the most commonly quoted sources of information about folic acid and vitamin and mineral supplements in pregnancy, mentioned by 16 women (15%). Other sources of information were: newspapers (15 women), verbal information from a general practitioner (14), television or radio (13), written information from a general practice surgery (five), midwife (five), friends (three), written information from a hospital (two) and health books (one woman). Four women (two medical students, a doctor and a health visitor) had received information as part of their professional training.

The study showed that women were more likely to be informed for second and subsequent pregnancies rather than their first pregnancy. They therefore do not benefit from reducing the risk of neural tube defects in their first pregnancy. There appeared to be confusion about which vitamin and mineral supplements should be taken in pregnancy.

It is difficult to envisage any dramatic increase in the extent of awareness of folic acid among non-pregnant women as a result of only medical contact. Pre-conceptual counselling in the primary care setting is the ideal, but it is likely that not all women will seek advice. The public health campaign which targeted general practice surgeries was criticized for its low profile and its somewhat confusing image.[6] Women's magazines were the most commonly quoted sources of information both in this survey and in a study in Leeds.[2] Perhaps more use could be made of this source of influence. It may be worth studying the cost-effectiveness of this type of intervention compared with the more usual Department of Health poster and leaflet campaigns.

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Management of opiate dependence

Sir,
The editorial by Wilson and colleagues (September *Journal,* p.454) has outlined the appropriate management of opiate dependence. Acknowledgement of such management was long overdue.

It is a fact of modern medicine that it behoves all physicians to be aware of opiate dependence in their patients and to deal with it as they would any disease. To treat an opiate-dependent patient with contempt achieves nothing but exacerbation of the problem. Substance dependence meets all the epidemiological criteria that entitle any disorder to be classified as a disease. Why, therefore, should physicians not treat the condition? Admittedly, many drug-dependent patients exhibit manipulative and antisocial behaviour, but if managed correctly this type of conduct can be easily overcome or, alternatively, the patient can be dismissed from the practice. All physicians set limits of their services and expect patients to reciprocate. The same rules apply for drug-dependent patients.

A considerable number of physicians view the management or treatment of opiate dependence with distaste.[1] Little do

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'[1] 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.[2] 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 disenfranchized grievers;[3] '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-