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-