It is just possible that long term benzodiazepine use really does not affect the Crown–Crisp score. It is the responsibility of the authors to produce evidence that this is the case before making such an assumption, however. In the absence of this evidence I feel it is much more likely that what they have identified is not a subgroup among their patients but the adverse affects of long term tranquillizer use.

This is important as it is tempting to blame the patient for his or her dependence rather than ourselves for allowing dependence to develop. Ultimate responsibility for prescribing always resides with the doctor, and we must accept the blame for adverse affects of our medication as openly as we claim credit for its benefits.

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Anticipatory care of the elderly

Sir,

Drs Jachuck and Mulcahy pose an interesting and important question in their article (May *Journal,* p.207) on what constitutes the type of minimum data set necessary to promote anticipatory care of the elderly. Their study revealed a lack of interest in periodic screening of older people and the authors appeared to see this as a basis for redoubling efforts to argue the case for screening.

However, poor support for screening may be a recognition of the absence of solid, consistent evidence of the benefit of regular health check-ups of all older people. This may be because public health strategies are better suited to the detection of asymptomatic disease, such as hypertension or intra-epithelial carcinoma of the cervix, than to finding unexpressed health needs in the older population.[1] Even if there were research evidence to support universal screening of the elderly, the resource implications are considerable[2] and there is, at the very least, a theoretical case for more attention to be paid to the use of routine contacts with older people — 90% of over-75-year-olds are seen at least once a year by general practitioners — for anticipatory care.[3]

Drs Jachuck and Mulcahy envisage a computerized screening programme but as it becomes easier to collect large amounts of information, more research like this and wider discussion will be essential to help define what constitutes an adequate data base to merit 'good practice' in the care of the elderly.

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Hospitals for the mentally handicapped

Sir,

Those of us who have been at the forefront of the moves towards proper (not community) care of people with mental handicaps will be surprised and disappointed by the editorial on hospitals for the mentally handicapped (March *Journal,* p.97). We are told that community care is a 'seductive' concept which apparently cannot be achieved. Dr Livingstone argues that even if the hospital patients could be released, this would make the care of the mentally handicapped in the community worse. He then cites all the negative reasons why community care for the mentally handicapped cannot take place — they will be unhappy, they have more mental and physical disease, and we need money to look after them before they get out. Finally, he tells us that the hospitals are really nice places which should be developed as a good idea — 'a potential haven in times of need'.

What Dr Livingstone seems to forget is that we are talking about the basic right of every human being to develop his or her full potential without being shut away in 'tribal homelands' where the reason for admission is not medical need but lack of intelligence as measured by discredited techniques. Such hospitals are as anachronistic as labour camps, and civilized societies have found much better ways of solving the undoubted clinical problems of multiply handicapped people. Normalization is an opportunity for intellectually handicapped people, not the professionals who care for them. To delay the process of such freedom on the pretext of protecting society and 'the mentally handicapped' is tantamount to delaying the abolition of slavery because the good white citizens would not like it, and the slaves could not handle it.

Here in this department of general practice, we have a unique association whereby the New Zealand Institute of Mental Retardation and its staff are based in the department. We seek to encourage government to develop and maintain services consistent with the philosophy of normalization:

1. Services should try, as far as is possible, to use ordinary methods and facilities which are valued in the local community, in order to help people with intellectual handicaps to live ordinary lives, that is to use ordinary schools and social and general practitioner services.
2. The status of people with intellectual handicaps should be enhanced by services, both by what is done and how it is done.
3. Services must recognize that people with intellectual handicaps are individuals with their own unique abilities, preferences and needs, that is they should be able to choose their own family doctor.

General practice as the focus of personal and individual, primary and continuing care is ideally suited to take up the challenge of a new era in the care of people with intellectual handicaps. Let us not waste energy in defending the mistakes of the past but prepare ourselves for cooperation with those delivering educational and social services in a difficult challenge which requires to be faced urgently.

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Post-traumatic stress disorder

Sir,

In drawing practitioners' attention to the possibility of delayed post-traumatic stress disorder in Falklands veterans, Drs Jones and Lovett have performed a valuable service (January *Journal,* p.34). They and others writing on the topic, however, may have inadvertently given the impression that army doctors are unaware of the problems, or unable to help.

In fact, all army doctors are systematically taught about battleshock, as we call it, at the Royal Army Medical College. A comprehensive address on the subject was printed in the *Journal of the*