were unfavourable. Collings,[2] Hadfield,[3] and Taylor[4] were sharply critical of the quality of the worst practices and unflattering about a lot of others. Morale was at its lowest.

Practice as it was under the National Health Insurance would not do for the future but creative planning in 1948 was concentrated on the hospital service. However, two events in the early 1950s gave an opportunity for change. First, the Danckwerts adjudication, accepted by Government, made a fair settlement of the general practitioners' pay claim, including four years retrospection. A new system of distribution was negotiated without rancour, favouring group practice and new entrants, and providing for training. Those with medium sized lists gained some advantages as a means of promoting quality rather than sheer numbers — a point that must not be lost when the white paper proposals are considered. However, the anomalies of indirect and partial payment for expenses, especially rent and staff costs, were not addressed and, until a Royal Commission and the later general practice charter, doctors who provided better facilities for patients did so at their own expense. The one contribution toward better premises was made by the doctors themselves through their interest-free group practice loans scheme — a piece of altruism too often forgotten.

The second hopeful event of the 1950s was the foundation of the College of General Practitioners with the aim of fostering quality in practice by improved training for entrants, continuing education in practice, better practice organization and research. It has been fascinating to watch the way in which the early initiative of an oddly assorted but enthusiastic group has passed on to a second, third and soon a fourth generation of leaders with a progressively broadening concept of the function of the College. The change from monolithic medical practice to multidisciplinary primary care came gradually — a few practices in the mid 1950s and then a general realization of the benefits of working, first with community nurses and later with others. Geoffrey Marsh's Mackenzie lecture[5] describes the evolutionary process. The charter negotiated by Kenneth Robinson with a medical group led by Jim Cameron made generalization possible; it did not initiate the change.

Good medicine will not be generated by financial promotion, on which the white paper places too much emphasis, but financial disincentives can obstruct it. Health care cannot be standardized, uniformly packaged and delivered at the cheapest rate without sacrificing the elements of continuity and humanity. The NHS, like all organized health services, will never have the resources it could use effectively and it must be cost conscious. We do not want larger lists with less satisfactory care for each patient; nor do we want needlessly costly payment for lists too small to provide a full medical job. In recent years the funding of the NHS has been damagingly restricted, more so in the hospital and other community services than in general practice. Too much has been made of head counts of things done and not enough of the rising toll of services left unperformed.

The white paper is still concerned with some of the problems that were not solved when the charter was negotiated, such as the setting of an age limit for doctors and a firmer commitment to continuing education, but it also allows us to reach a new agreement, bypassing some of the obstacles that have seemed immovable for so long. If the opportunity to plan for quality is not obscured by a preoccupation with cost control the College's long campaign for review of outcome in practice could take a long step forward. Hopefully the same obligation will be accepted by all the specialties, for reasons well expressed by Hoffenberg.[6] The generalist and the specialist must come together if the true interests of the people and the profession are to be served.

The white paper makes much of prevention and, although wider preventive programmes require the sort of action which successive governments have failed to take to prevent commercial promotion of health destructive behaviours such as smoking, it will be through primary health care that the message will be pressed home. For this to succeed there must be organized exchange between the practice group and the practice population of the kind the National Association for Patient Participation has been seeking for 15 years.

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Benzodiazepines: time to withdraw

IT has been estimated that between 15 and 44%[1,2] of long term users of benzodiazepines may be expected to show withdrawal symptoms when the drug is stopped. These symptoms emerge in the first week after stopping the drug but may also develop if the dosage is reduced. The withdrawal syndrome may last for up to three months or even longer with some patients.

The withdrawal symptoms are often similar to the anxiety symptoms for which the benzodiazepine was being taken but may be distinguished from a recurrence of anxiety by an increased sensory perception, with hypersensitivity to noise, light, pain and touch. Other symptoms which are frequently reported include headaches, dizziness, disturbed sleep and a disturbed gastrointestinal tract.

The best way of avoiding dependence is to avoid unnecessary prescribing. Many patients presenting with anxiety may be suffering from depressive or other neurotic disorders that could be better treated with antidepressants, which are not associated with dependence.[3,4] Some patients are more likely to become dependent than others, especially those with a previous history of drug and alcohol dependence, dependent and obsessional personalities, and others with long-standing neurotic symptoms. The evidence for the usefulness of benzodiazepines in minor anxiety states is weak. They should properly only be used for short courses at the lowest possible dose. The use of an intermittent dosage regimen with instructions to take a drug holiday, say every two or three days, is likely to reduce both overall intake and dependence. Brief counselling may often help to avoid a prescription for a benzodiazepine. Benzodiazepines should not be used for minor sleep disturbances and a shift away from their easy availability as hypnotics would be welcome.

The major problem facing the general practitioner now is how to manage the withdrawal of patients who may be dependent on benzodiazepines. Although some people seem to be able to

withdraw abruptly, a sudden cessation of treatment can lead to severe withdrawal symptoms including fits or confusional states.[5,6] A slow reduction in treatment is therefore preferable and, as withdrawal symptoms tend to emerge four or five days after the last dosage reduction, it may be wise to adopt a weekly reduction programme. Withdrawal may be more successful if the dosage reduction programme is flexible and takes account of the withdrawal symptoms seen. Most patients will tolerate a fairly rapid reduction in dosage spread over a few weeks but those who have been taking higher doses or have a history of withdrawal problems will need longer. There is no definite length of programme to recommend — withdrawal periods varying in length from four to 16 weeks have all been suggested.[7-9] Much will depend on the individual patient and a flexible approach is required. On reaching the lowest doses it may be helpful to move towards an intermittent dosage and longer drug holidays, with the patient taking the drug on alternate days, then every third day and so on.

In a small proportion of cases the dependence appears to be intractable and specialist help may be necessary. If the difficulties are so great that the clinician decides not to continue with a withdrawal programme, then any prescriptions from then on should be recognized as being given for dependence and not for the original indication.

Several workers recommend changing from a short acting benzodiazepine, such as lorazepam, triazolam or temazepam, to a long acting one, such as diazepam or nitrazepam, as the gradual fall in benzodiazepine activity is less likely to produce withdrawal symptoms.[8,10] Substitution with antidepressants has been used and found to be most effective if it is started four weeks before the withdrawal programme begins, and tapered off several weeks after the benzodiazepine has been stopped (Rickels K, personal communication). Beta-blocking drugs in low doses, for example propranolol 40 mg twice daily, may also reduce withdrawal symptoms.[5]

During the withdrawal period the patient will need support from the general practitioner, and perhaps also a psychologist or community nurse, who should maintain close contact with the patient, preferably at weekly intervals. This is important in helping to provide reassurance about the withdrawal symptoms but also in monitoring the development of possible depression and of undesirable coping mechanisms such as abuse of alcohol. Relaxation therapy and training in anxiety management skills appear to be only moderately effective. Cognitive therapy, if available, may be more effective.

It is important to reinforce the motivation of the individual to withdraw from benzodiazepines. This may be assisted by enlisting the help of family and friends. The success of the withdrawal programme hinges on the amount of social support available.

After dependent patients have been withdrawn from benzodiazepines nearly half of them may remain vulnerable to stress for a period of up to six months.[1] Additional support may be necessary over this time so that the patient can develop new coping mechanisms. Patients who revert to taking benzodiazepines are most likely to do so during this period. Once this period has elapsed it would be wrong to regard any new symptoms of anxiety as related to dependence on benzodiazepines.

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Interviews in the selection of partners, trainees and medical students

GENERAL practitioners are already involved in the selection of their trainees, partners and associated staff, but as their involvement in teaching and other undergraduate matters increases they will be increasingly included in student selection panels. Most UK medical schools normally interview candidates — in 1981, only eight did not do so.[1] The selection system is by far the most important determinant of who becomes a doctor: in 1984, it excluded over 6000 applicants.[2] By contrast, only 16 medical students left unqualified during the same period because of failing their final examinations (personal communication, Universities' Statistical Record). As in the selection of partners, trainees and other staff, the interview is a key part of a process which, if it errs, can have profound future repercussions.

Can interviews aid the selection of staff and students? The evidence is that, supplemented by information on an application form, the interview is a powerful selection tool. Predictions about candidates following interviews can be far more accurate than those from background data alone,[3] although some matters are more accurately assessed than others; for example, extraversion can be judged quite accurately whereas neuroticism cannot.[4] But other factors are measured more precisely by other components of the selection system: academic ability is unlikely to be assessed better in a short interview than by lengthy school examinations and school reports based on considerable experience of candidates.

Unfortunately, interviewers vary widely in their ability to