in the general field who have been struggling with their care. While the short term effect is beneficial to patients and their families, the longer term effects of such intervention may provide for alternative rather than complementary resources.

It is possible that the development of palliative medicine as a distinct specialty may add to this isolation, when it may be most effective in drawing together those involved, sharing skills and strengthening the roles of those in primary care.

The nursing profession has benefited greatly from the appointment of Macmillan nurses. These nurses must have had community training and not only do they readily understand the problems of district nurse colleagues, they will also have developed an understanding of the changes in family dynamics that follow a serious illness in the home. The major components of the clinical nurse specialist role are advanced clinical practice, teaching, management and research. These are closely mirrored by the activities of the physician in palliative medicine. Doctors training in palliative medicine should have experience in general practice.[2] Acceptance of such experience as mandatory may encourage the development of physicians in palliative medicine who understand and support the general practitioner's primary role, and who work towards the management of terminal illness within the primary health care team.

Palliative medicine has come a long way since 1967. Paradoxically, in order to develop effectively in the future it must be seen as a specialism that requires skills that can be acquired by all. The general practitioner and the district nurse must remain as the prime workers and any further growth in hospice care should be towards supporting those who already deliver that care. The appointment of physicians in palliative medicine could be a major step in providing this support.

The Association for Palliative Medicine has considered the problems of teaching and training in palliative medicine and is continuing to develop plans for the future. The development of the post of physician in palliative medicine should be guided by aims similar to some of those outlined by the Association for Palliative Medicine. He or she should awaken and cultivate interest in palliative medicine and be proactive in the education of other health professionals. He or she should be aware of, and investigate further, not only physical and psychological but also social and spiritual aspects of disease and should further the understanding of these aspects by appropriate research.

The development of a new medical role in palliative care may be seen not as a replacement for that of the hospice medical director, which may be appropriate in many situations, but as an alternative where the needs of the community and of existing services demand. The preparation for this role must, however, be necessarily different from that needed for the traditional role, demanding the skills of community care alongside an awareness of the special needs of dying patients and their relatives, together with an interest and understanding of educational requirements.

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Double standards for screening

Sir,

Double standards are being applied to screening elderly people and surveillance of children under the age of five years, as experienced colleagues have pointed out in the debate on paediatric assessment.[1] Child health surveillance yields relatively few problems that need or are amenable to medical management, is done well by health visitors and better by parents, yet has been the subject of prolonged campaigning by general practitioners[2] and is now firmly embedded in the new contract for general practitioners.

Assessment of elderly people, on the other hand, is likely to find that one in five of those aged 75 years and over have some degree of depression, with 3% or so having severe depression with a poor prognosis unless adequately treated.[3] Between 6% and 12% of the elderly will show some degree of dementia,[4] and a large minority of their carers will demonstrate significant stress and strain.[5] These two groups of elderly patients overlap only slightly, so that up to 30% will have psychiatric morbidity to some degree.

General practitioners underdiagnose dementia[6] and undertreat depression[7] in elderly people, yet training in assessment techniques is not part of the requirements of the new contract and evaluated screening instruments have not been proposed for use by other health workers. Worse still is the temptation for overworked family practitioner committees to offer their general practitioners checklists for assessment of elderly patients in which inadequate descriptions of pathological mental states — aggression, confusion, withdrawal — are buried among questions relevant to community surveys of need but inappropriate for case-finding and problem-solving in general practice.

To ease workload elderly patients who have been seen in the course of the year by district nurses, a health visitor or their general practitioner may well be counted as already 'assessed', so that information of dubious value may be collected on those not seen, who may turn out to be healthy members of the biological elite. Significant but relatively small changes in cognitive function heralding dementia and impending decline in functional ability may be overlooked in medical consultations about other problems, or by nurses concentrating on immediate tasks, while the somatic preoccupations of the elderly depressive are overshadowed by their all-to-real physical problems.

Checklists focus attention and are better than neglect, but training in the use of screening instruments and in diagnostic techniques remains a necessity that the new contract ignores. Is this the way to overcome medical nihilism towards psychiatric illness in the elderly, or to support the carers upon whom 'care in the community' really depends?

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Screening elderly people

Sir,

In their timely paper on screening elderly people in primary care (March *Journal,* p.94) McEwan and colleagues observed 16 deaths among 151 patients in the test group and 23 deaths among 146 in the

control group. They observed that 'The death rate in the test group (10.6%) was not significantly different from that of the control group (15.9%)'. Presumably the sample size was determined by the list of the practice in question, but any study which failed to find a significant difference between mortality rates of this magnitude was too small.

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The prevention of convulsions during benzodiazepine withdrawals

Sir,

Benzodiazepine misuse and dependency are common problems in general practice.[1] While many patients are dependent solely on these drugs, poly-drug abusers also include them in the range of substances which they misuse.[2] Withdrawing from such misuse may be straightforward but a substantial proportion of patients suffer from various complaints, with major convulsive seizures being among the most serious objective disorders encountered.[3] To minimize the risks to patients during withdrawals it is now generally recommended that a gradual reduction in dosage takes place.[4] Four to 16 weeks or even longer are advised though confusion may be caused by the 10 day course of detoxification recommended by one authorative source.[5] Personal experience of dealing with relatively large numbers of patients admitted to a residential drug rehabilitation unit suggested that a short course of oral diazepam was effective in preventing convulsions during withdrawals. The study reported here was designed to test this.

All patients with a history of benzodiazepine misuse admitted to the unit from 15 September 1989 to 18 December 1989 were prescribed 60 mg of oral diazepam per day. This was reduced in 10 mg steps per day to zero over six days. No other drugs with any potential anticonvulsant action were given.

Nineteen patients were eligible for the study. Four defaulted during the first six days of residence and were excluded. Of the 15 patients remaining in the study five were women and 10 men; their age ranged from 18 to 27 years. Nine (60%) had a history of convulsions during previous benzodiazepine withdrawals, 13 (87%) had been injecting themselves with benzodiazepines and all patients had been taking other substances. Temazepam was the most frequently abused drug with a mean daily dose in the month prior to admission of over 350 mg. The interval between the last self administered illicit dose and the first dose of prescribed diazepam ranged from 10 to 96 hours (mean 39 hours). The patients remained in residence and under observation from 11 to 58 days (mean 38 days).

No patient convulsed during the study. While no formal attempt was made to assess other symptoms during detoxification, no major pschiatric disorders developed. Indeed it was apparent that many patients found the process less demanding than they had anticipated. The optimistic and caring environment created in the unit by its staff may well have contributed to this positive outcome. It seems probable that such support, especially from close family members, would be equally helpful in general practice. With a significant proportion of poly-drug abusers spending periods in prison and hospital it is likely that the short course of detoxification described here could also prove useful in these areas.

It is concluded that the standardized 'sliding scale' of diazepam outlined above is effective in preventing benzodiazepine withdrawal fits when used in a residential setting.

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Characteristics of long-term benzodiazepine users in general practice

Sir,

The paper by Simpson and colleagues (January *Journal*, p.22) made interesting reading. As a psychiatrist with research interest into benzodiazepines I have been studying the same phenomenon from a different angle.

Much of the published research on the management of benzodiazepine dependence has been based on hospital outpatient samples and I suspected that these findings might have limited applicability to patients in general practice. I have therefore made a comparison of patients attending a hospital clinic for treatment of dependence (n = 60) with long term benzodiazepine users in a local general practice (n = 104). The characteristics of the latter group agree almost exactly with the findings of Simpson and colleagues. The model patient is aged, physically ill and taking hypnotic benzodiazepines in 'normal' thereapeutic doses. The hospital clinic patients were on average 25 years younger (mean 40.2 years) and were using higher doses of anxiolytic medicine (mean 38 mg diazepam equivalent daily). Major physical disease was uncommon (12%) but major psychological disease was common (64%). The most dramatic difference concerned the motivation of the patient to withdraw from their drugs. All the hospital patients rated themselves as at least moderately motivated to discontinue use. Determined efforts were made to assess the motivation of the general practice patients to discontinue their drugs. A mail shot, telephone contact with patients and discussions with general practitioners and other health workers resulted in only two consultations.

I would concur that the management strategy applicable to younger anxiolytic dependent patients in the hospital setting probably has little relevance to the population of benzodiazepine users in general practice. However, in view of seemingly poor motivation on the part of patients it is difficult to know what the best approach is.

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The patient as consumer?

Sir,

Professor Campbell's editorial 'The patient as consumer' (April *Journal*, p.131) has highlighted ethical problems which are causing great concern, not only among the medical profession, but also among the patient population. The title would perhaps have benefited by the addition of a large question mark, not only because the concept of patient as consumer is highly controversial and far from achieving general acceptance, but also to indicate that widespread debate is necessary on this all-important issue.

The Patients' Liaison Group of the Royal College of General Practitioners has great difficulty in equating the patient with consumerism. It has for a number of years been concerned to strengthen the