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

role of patients in determining their own care. By concentrating on the relationship between professional 'providers' and lay 'consumers' Professor Campbell ignores the positive aspects of enabling people to make choices about their health. In doing so, patients are in a better position to ensure that the services they receive reflect their needs more closely.

The perspective of consumerism has recently been forcibly introduced into a whole range of public sector services. In the NHS the theme of consumerism was introduced around 1983 when Roy Griffiths produced his first report, *The enquiry into NHS management,* and was sustained and built upon in subsequent green and white papers, notably the consultative document *Primary health care: an agenda for discussion,* the white paper *Promoting better health,* and the NHS review *Working for patients.* All these papers assert that proposed changes are intended to make services more responsive to the consumer and for the consumer to be given wider choice. Given that wider choice, it seems highly improbable that the average patient would wish to be considered as a consumer in matters of health care. In effect, 'consumer' is an accommodating term, imposed on the patient, in order to introduce into the NHS a form of competition, and a market oriented philosophy.

One could argue that the patient is not merely a consumer and, indeed, could more appropriately be described as a partner — a provider of information and case histories, a presenter of illness and disease, a contributor in helping the professional reach a decision, a person actively participating in his or her own health care. Conversely when the new legislation is implemented the real consumers will be those placing contracts with and purchasing services from the hospitals; that is, district health authorities and budget holding practices. The six characteristics of a market relationship summarized by the philosopher Robin Downie,[1] and quoted by Professor Campbell, apply more appropriately to this alternative interpretation, whereby the trading partners are the budget holding general practitioners and the district health authorities on the one hand, and the hospital suppliers on the other.

Despite the repeated assertions that services are to be made more responsive to the patient and that the patient is to be given wider choice, it is difficult at this stage of untested theories and excluded pilot studies to appreciate where these choices lie. Patients will be able to change their doctor and move from one practice to another, but as practices grow larger, even that choice will become limited. It is far from likely that patients will be invited to participate in drawing up contracts which could incorporate specified patient choices and known preferences. Instead patients will be offered the medical treatment they seek where the purchasers have chosen to place their contracts and there is no reason to assume that this will be the patients' choice. This cannot be regarded as a genuine market situation from the patients' point of view. A trading partner would never accept such restricted terms.

It cannot be denied that the market approach implicit in consumerism does potentially enhance the position of the patient, albeit the more confident and articulate patient, but this enhancement can also be found within a participative relationship, where professionals share their decisions with their patients.

Just as there are confident and articulate patients so there are vulnerable patients, some so frightened, confused and emotionally distressed that choices and decisions have to be made on their behalf. It is vitally necessary that protection should be guaranteed to these vulnerable patients. A bill of rights, or patients' charter, such as that already produced by the Association of Community Health Councils in England and Wales, has much to recommend it, not least, as Veatch suggests[2] because it introduces a social dimension so sadly missing in individualized contracts and covenants. In any 'just' society there must be an element of social responsibility for ensuring an equitable sharing of medical provision. In this era of 'cash limiting' there has to be a notion of fair shares; the Patients' Liaison Group is of the opinion that the major flaw associated with consumerism in health care is the ideology of focusing on the individual rather than accepting corporate responsibility for the community.

The unique relationship of trust and understanding between doctor and patient which has evolved over the years will suffer immeasurably if it is seen only in commercial terms. It is being assumed that all patients can converse on equal terms with the doctor; that patients can compete with one another for services; and that patients accept and recognize the full implications of a trading relationship. This is far from the truth. Health care is qualitatively different and should be recognized as such.

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Prevalence of iron deficiency anaemia

Sir,

Dr Grant's community based study (March *Journal,* p.112) found 17% of preschool children to have iron deficiency (ferritin level $<10\ \mu g\ l^{-1}$) and 3% to be anaemic (haemoglobin level <10.5 g dl^{-1}). In a community based study in Sligo, north-west Ireland, Armstrong[1] found similar results — 40% of the adolescents tested had iron deficiency (ferritin level $<10\ \mu g\ l^{-1}$) while anaemia was found in 13% of males (haemoglobin level <13.0 g dl^{-1}) and 7% of females (haemoglobin level <12.0 g dl^{-1}). These two studies suggest that iron deficiency is more prevalent than might be expected.

Dr Grant's suggestion of taking blood samples from all pre-school children when they present for the measles, mumps and rubella vaccine may not be practical but perhaps a more sympathetic ear to the request for a 'tonic' or iron supplement would be appropriate.

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Diabetic care in general practice

Sir,

I was interested to read the paper by Farmer and Coulter on diabetic care (February *Journal,* p.56). This was a stimulating paper and the hypothesis discussed, that organized general practice care reduces the rate of hospital admissions, is important.

However, if the admission rates generated in the paper are applied to the 'average practice' with 7500 patients,[1] then this suggests a difference between 'good' and 'bad' practices of less than one admission a year in total to distinguish their varying standards of diabetic care. This does not appear to be a very sensitive discriminator and it would have been reassuring to see the original total chi-squared value and the deviation to help assess the clinical significance of the trend result.

I would endorse many of their com-