industry. We were told that the then-new SSRIs were safe, effective, and non-addictive, they corrected a chemical imbalance in the brain, and that GPs were massively under-recognising and undertreating depression. The professional consensus emerged that it was good practice to prescribe to anyone who had 'biological symptoms of depression' for 2 weeks or more. The studies backing these assertions covered a standard 8–12 weeks.

Now we are faced with huge prescription numbers, driven at least in part by long-term prescribing, for which there is a very flimsy evidence base. Many people have developed discontinuation symptoms when stopping these drugs, been told by their doctors that these represent a relapse of their original condition, and can now count the years over which they have been dependent on prescribed drugs.

The RCPsych has moved its position, as evidenced by its recent publication *Stopping Antidepressants*,[3] endorsed by the RCGP. This is welcome after years of denial from both Colleges that there was a significant problem with SSRI withdrawal. The recent past-president of the RCPsych recently told *Telegraph Magazine*, *'that prescription figure is high. However, most antidepressants are started by GPs.'*[4]

This is important now. Not only are there large numbers of people who need help in coming off their medications, but we also risk adding to their number if the stress and exhaustion of COVID-19 and its aftermath are also subjected to the seemingly irresistible pressure to medicalise human distress.

General practice, and the RCGP in particular, needs to resist the urge to defensiveness, learn the lessons of experience,[5] and show leadership in addressing this problem.

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Correction

In the editorial by Greenhalgh T and Rosen R, Remote by default general practice: must we, should we, dare we? *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/bjgp21X715313, the following details have been added: Funding: This work was funded by the UKRI COVID-19 Emergency Fund (grant reference: ES/V010069/1).

DOI: https://doi.org/10.3399/bjgp21X715697