invasive cardiac evaluation should be referred for invasive electrophysiological studies. Patients with vasodepressor syncope and mitral valve prolapse may respond to β adrenergic blockade. Effective treatment of the effort syndrome remains difficult. Symptoms of the syndrome often occur in clusters during periods of increased emotional or physical stress; in such people β blockers may be targeted at symptom peaks rather than given regularly.

Between 3% and 10% of people with symptomatic mitral valve prolapse develop potentially life threatening complications. These are congestive heart failure due to progressive mitral regurgitation or mitral regurgitation associated with ruptured chordae tendineae, infective endocarditis, cerebral embolism, and sudden death. Studies by Marks and others indicate that many of these complications occur most commonly in patients with thickened mitral valve leaflets and are more likely to occur in older men with prolapse.¹³⁻¹⁵

Congestive heart failure due to severe mitral regurgitation associated with myxomatous degeneration and mitral valve prolapse may respond for a time to treatment with diuretics and vasodilators but is now the commonest indication for mitral valve replacement in elderly people and for mitral annuloplasty at any age.¹³⁻¹⁵ Flail mitral leaflet virtually always requires mitral valve replacement or repair.¹³⁻¹⁵

Infective endocarditis has been reported to occur in 2-8% of patients with known mitral valve prolapse.¹³⁻¹⁶ Moreover, retrospective analyses indicate that mitral valve prolapse was present in up to one third of cases of documented infective endocarditis.¹⁶ Important risk factors for infective endocarditis in patients with mitral valve prolapse are the presence of mitral regurgitation and thickened (myxomatous) mitral leaflets.¹³⁻¹⁶ The pathogenesis, clinical features, prognosis, and therapeutic implications of infective endocarditis associated with mitral valve prolapse are similar to those associated with other forms of mitral valve disease.¹³⁻¹⁶ Antibiotic prophylaxis should probably be reserved for those with mitral regurgitation or thickened mitral leaflets, or both.¹³⁻¹⁶

Cerebral embolism occurs with a disproportionately high frequency in young people with mitral valve prolapse and probably in older people as well.^{13-15 17} Thrombi have been detected on mitral valve leaflets of patients with mitral valve prolapse who have died of cerebral embolism.¹⁷ Advanced age seems to be the main risk factor.^{13-15 17} Cerebral embolism seems to occur with equal frequency in those with normal and thickened mitral valve leaflets. Shortened platelet survival time and increased platelet coagulant activity have been

reported in studies of patients with cerebral embolism and mitral valve prolapse,¹⁷ but whether this is a cause or effect of thrombosis and embolism is uncertain. The efficacy of antiplatelet therapy in preventing thromboembolism is unproved, but it is often used empirically. Warfarin should be used in patients who have suffered previous thromboembolic episodes. Sudden death in patients with mitral valve prolapse is extremely rare and is usually due to sustained ventricular tachycardia or ventricular fibrillation.¹³⁻¹⁵ In addition to thickened mitral valve leaflets, the presence of delayed repolarisation is a risk factor for sudden death. Treatment should be guided by invasive electrophysiological testing in people with mitral valve prolapse who have had ventricular tachyarrhythmias.

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What social workers need

A General Social Services Council, better education, and a wider range of employers

Social work has been harshly judged during the past 20 years on some spectacular failures in child protection. Its successes—monitoring 45 000 children on child protection registers and helping to halve the number of children in public care—are largely unreported. Its achievements with adults are overshadowed by current preoccupations with children's issues. Action is now needed on three fronts to enable social workers to flourish: the professional institutions of social work, education and training, and the agencies that employ social workers.

Social workers engage with important, sensitive, and

private aspects of the lives of individual people and families. Their work directly affects hundreds of thousands of citizens. Yet social work is not regulated by an independent body: qualifications for appointment (except in the case of approved social workers) and arrangements for discipline are matters for the employer alone. A proposal to remedy this by establishing a General Social Services Council is currently before the secretary of state. At little or no cost to the public purse the council would regulate the conduct of individual practitioners and set standards of competence for education and training. Social workers in residential and community

settings head the list of priorities for registration by the council.

Education and training are currently among the most important issues in the personal social services. Community care requires social workers to extend their range by adding budgetary, managerial, and coordinating responsibilities to their traditional tasks of assessment and casework. Training must also cover the knowledge and skills required for working with both children and adults and provide the ethical and legal grounding that social work needs. Two years of full time education is too short a time to establish competence across the whole range of a social worker's statutory duties; the issue is not whether a third year is desirable but whether it should be spent before or after qualification.

Social workers often operate in circumstances where moral values are confused and in conflict and where no single outcome is likely to satisfy all those concerned. Compulsory admission, child care, child protection, fostering and adoption, assessing risk in community and residential care—all these are matters on which social workers encounter divided views on values, principles, and policy. Social work must therefore have a secure ethical basis for its professional and educational structures.

Practitioners confronted by moral dilemmas and insoluble problems also need the guidance and support of a comprehensive professional organisation. Its advice and findings then form part of the bedrock of professional education. The absence of such a professional structure hampers the incorporation of ethical and technical elements into education. The proposed general council would fill this gap effectively and economically.

Social work's close association with local government has brought it both costs and benefits. Social workers, in a role that requires professional self-direction, are asked to function as part of the welfare bureaucracy and as front line troops performing statutory duties. But local government also provides social workers with a crucial role in protecting vulnerable people and in securing valuable services for them. It will remain a rewarding setting for the practice of social work, and social workers will continue to make an important contribution to the welfare of the community from a base in local government. The necessary condition is that they receive responsible political leadership, effective management, and proper resources.

The narrow focus of statutory services now prevents social work from directly addressing the consequences of unemployment, poverty, and homelessness. A new statutory framework is required for services to adults that redirects the energies of social work to these needs and fulfils all the aspirations of community care policies. Social work should also seek to develop as a professional activity in voluntary and private agencies and in the NHS. The requirement for local authorities to meet the health service's need for social work has broken down in significant areas. Health services should once again be able to employ social workers, and social work should be one of the services offered by NHS hospitals and trusts, community health services, and general practices.

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Short acting benzodiazepines

Dream drugs or nightmare?

Benzodiazepines with a short half life have recently become the subject of considerable controversy, which culminated in the suspension of one such drug, triazolam, by regulatory authorities in several countries including Britain. In addition to rebound phenomena occurring when treatment is stopped, it has been claimed that the rapid elimination of these drugs may result in withdrawal symptoms during treatment—including amnesia, delirium, psychosis, behavioural disturbance, and affective disorders. The manufacturers of triazolam, however, have consistently maintained “full confidence in the efficacy” of their product,¹ and recently Jonas claimed that the conclusions of triazolam's most vociferous critics result from “poor methodology, inadequate test measures, and improper interpretation” of data.²

Here we address two questions fundamental to the debate. Do the alleged side effects occur, and, if so, are they more commonly observed with triazolam than with other benzodiazepines? A review of spontaneous reports to the United States Food and Drug Administration showed that side effects were reported up to 100 times more commonly for triazolam than for temazepam per prescription,³ and the Committee on Safety of Medicines has also received an apparent excess of reports of memory and affective disturbance associated with triazolam.⁴ Obviously case reports and drug monitoring data are open to many sources of bias, and a drug that has been the subject of media attention may attract closer scrutiny of its apparent adverse effects by both doctors

and their patients. The number of reports is not, however, easily ignored, particularly when combined with the results of controlled studies.

The least controversial symptom is rebound insomnia. A virtually complete consensus exists that this often occurs when any benzodiazepines, including triazolam, are stopped.⁵ Indeed, rebound insomnia can even occur after a single dose of triazolam.⁶ Kales and colleagues found that the sleep of insomniac patients was poorer relative to baseline after they stopped both triazolam and temazepam (short and intermediate acting benzodiazepines respectively) but that the size of the effect was greater with triazolam.⁶ Although Jonas² points to multiple publication of data from the same group's earlier study⁷—which may have given a false impression of the weight of the evidence—the new study confirms this group's results.⁶ More importantly, it is consistent with independent work by other groups. These have shown that though it is certainly not unique to triazolam, rebound insomnia is most common and severe for compounds with short half lives.^{5,8}

Probably all benzodiazepines have memory impairing side effects,⁹ and, again, clear evidence exists that triazolam has amnesic side effects at therapeutic doses.¹⁰ In a comparison of data from two placebo controlled studies of the amnesic effects of triazolam and temazepam, Scharf and colleagues found that triazolam but not temazepam was associated with impaired delayed recall.¹¹ Similarly, in a parallel double blind study of flurazepam, temazepam, triazolam, and placebo,