diazepine should be changed to a long acting preparation before withdrawal. A balance has to be struck between slow withdrawal, which prolongs the symptoms but tends to make them less severe, and fast withdrawal, which leads to more intense symptoms lasting for a shorter time. Though no pharmacological treatment will abort the withdrawal symptoms, propranolol will attenuate some features,[12] and on the basis of experience with withdrawal of alcohol and opiates clonidine might be expected to have a place in treatment. In low dosage antipsychotic drugs are effective tranquillisers and have no risk of pharmacological dependence; but unfortunately they seem to have no value in treating the withdrawal syndrome. Indeed, one study with oxypertine suggested that such drugs might accentuate the withdrawal symptoms, possibly through their action in blocking dopamine receptors.[17] On the other hand, simultaneous treatment with a sedative antidepressant such as trimipramine or amitriptyline seems to lessen many of the symptoms. The place of psychological treatment also needs investigating, but group therapy has little effect in helping patients to stop their benzodiazepines.[18]

In terms of public policy, now that benzodiazepines have been shown to cause drug dependence should their use be more closely controlled—or even banned? We need to remember that these drugs have an important place in the short term treatment of anxiety and insomnia and are often invaluable in anaesthesia and epilepsy. What is needed is for them to be prescribed more carefully and with better awareness of their dangers. A course of treatment lasting for only several weeks is not likely to lead to dependence—though the "safe" period of drug prescription before the risk of dependence is not yet known. Flexible dosage given up to an agreed maximum dose a day also helps to keep total drug dosage down.[19] Although short term treatment is officially recommended,[20] this advice is often ignored, and far too many repeat prescriptions are given without adequate assessment. Cross tolerance occurs among benzodiazepines, so that if dependence occurs with one it is likely to be transferred to another. Diazepam is the most commonly prescribed benzodiazepine and has attracted more adverse publicity than other compounds, but this opprobrium may be misplaced. Benzodiazepines with shorter duration of action, such as triazolam and lorazepam, may carry a greater risk of dependence than their longer acting relatives: certainly their withdrawal symptoms occur earlier and are more severe than those of long acting compounds.[12 21 22] The explanation may be that withdrawal symptoms are more likely when blood concentrations of benzodiazepines fall rapidly after stopping the drug.[12] Indeed, the paradox may be that the attempt to make the prescription of benzodiazepines more acceptable by shortening their duration of action has led to a greater incidence of pharmacological dependence.

Finally, we should not assume that the long term prescription of benzodiazepines and the consequent high risk of dependence are evils to be avoided at all costs. No permanent consequences of dependence on benzodiazepines have been described, although Lader's findings of possible psychological impairment and neuroradiological changes after prolonged treatment need to be followed up.[23] Cigarette smoking probably represents the closest pharmacological cousin of benzodiazepine dependence and is far more dangerous—as is the addiction to alcohol that the patient may take up as an alternative. Many patients can stop regular consumption of benzodiazepines but find it difficult to cope without the occasional tablet, and this practice may be condoned if not formally encouraged.[24] Banning benzodiazepines is no answer to the problem of dependence. The response should be a period of probation and reassessment, not punishment.

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Protecting confidentiality

Not very long ago a patient could feel absolutely confident that whatever personal details he or she gave to a doctor would remain confidential. That was at a time when no one else had any need to see whatever notes the doctor might have kept, since most treatment began and finished with the doctor himself. Patients were only rarely required to produce medical information for other purposes, and the chances of that information being divulged inadvertently to anyone not entitled to see it were very limited.

More recently, however, three developments have shaken

the foundations of this easy system of medical confidentiality. Firstly, both the government and the courts of law have failed to recognise the principles on which the system is based. The Law Reform Committee and the Criminal Law Revision Committee have pronounced that there is little if any reason to treat confidential medical information any differently from that passing between a minister of religion and his flock, and medical confidences are given no privilege whatsoever in English courts of law. It takes only a short trip across the straits of Dover to reach a country where medical information enjoys absolute privilege in the courts. Worse still, the House of Lords has recently upheld the right of a lay councillor in local government to see confidential medical information in social service committee records even though she had nothing to do with the case and was not even a member of the committee.[1] Furthermore, last year the government itself attempted to introduce into the Police and Criminal Evidence Bill the opportunity for the police to obtain easy access to medical records on the flimsiest of grounds—an attempt which would have been successful had not doctors and the public reacted with outrage.

The second development has been the rapid growth in the number of agencies which are now concerned with the diagnosis, treatment, and management of patients. These agencies need access to appropriate information if they are to handle their cases efficiently and safely. They are, of course, committed to keeping confidential any information entrusted to them by doctors. But what happens when the information is processed into data which are then stored mechanically to facilitate access? The need to place controls on access to data on computers was emphasised by both the Younger Committee on Privacy[2] and the Lindop Committee on Data Processing.[3] The government decided to act, however, only when the commercial disadvantages became apparent of Britain's failing to implement the recommendations of the Council of Europe and the Organisation for Economic Cooperation and Development on the subject.

As soon as the Data Protection Bill appeared its safeguards against unjustified disclosure of medical information were seen to be seriously defective, and an interprofessional working group was set up under the chairmanship of Sir Douglas Black to secure appropriate amendments. At first the government was remarkably unhelpful, pointing out (with justification) that the bill does not compel anyone to disclose anything. The bill had already passed through the Lords and was well on its way through the committee stage before the group's first success was announced. It had persuaded the Minister of Health to take powers under the National Health Service Act to require all data users in the NHS to observe a code of guidance covering the handling and disclosure of health information.

The key issue in the code is the requirement that the doctor who is responsible for the patient should be consulted before disclosure. But what of data which has got on to computers outside the health service or which is based on information collected outside the health service? The group went back to the Home Secretary in March to point out that the position would not be secure until he took powers under the bill to require all data users to comply with a code of guidance in respect of health information, and the Home Secretary promised to do what he could "within the context of the bill." As the Commons committee has already dealt with the relevant clause in the bill, it will not be until the report stage—the last possible opportunity—that the government may act. If the Home Secretary has been persuaded to do what the group wants, patients will have good reason to thank Sir Douglas Black and the members of his group for the long and hard battle which they have fought.

The lesson of this bill is that at a time when large amounts of information can be speedily transferred around the world doctors must be vigilant if the traditional confidentiality of medical records is to be preserved.

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The sweet road to gall stones

Much has been discovered in the past 15-20 years about the mechanisms by which cholesterol gall stones form but less about their cause. We know from research on coronary heart disease that the way to identify risk factors is to do large scale epidemiological surveys—and especially prospective, longitudinal studies like the Framingham study. Such studies are only just beginning with gall stone disease. Case-control studies have been done but with inadequate numbers and with suboptimal techniques.

The new case-control study by Scragg and his colleagues in Adelaide is exemplary, with a large number of cases (267), the use of randomly selected but carefully matched controls from the community, and detailed statistical analysis. The authors plan a series of reports on the predictive power of nearly all the postulated risk factors: female sex hormones, multiparity, obesity, hypertriglyceridaemia, low plasma concentrations of high density lipoprotein cholesterol, and impaired carbohydrate metabolism. The first report (p 1113) deals with body weight, alcohol intake, and, especially, diet.

On body weight one finding was surprising: obesity was a risk factor only in women aged under 50. In men there was not even a hint that those with gall stones were heavier than controls. This is odd, since obese men certainly have bile which is supersaturated with cholesterol.[1 2] Admittedly, in the Adelaide study body fatness was assessed indirectly through Quetelet's index (weight divided by height squared), and this index may be the same in a person who is small boned and fat and one who is lean but big boned or heavily muscled. Direct measurements of body fatness must be made in a case-control study before obesity can be proved not to be a risk factor in men. The finding that older women with gall stones are not fatter than average has been foreshadowed in earlier studies. Those overweight women in whom obesity does lead to gall stones are perhaps destined to develop their stones early in their lives. Obesity does not make everyone a gall stone former.

The contribution of diet has been examined in the past by case-control studies and by experiments. Case-control studies have given confusing results, with excessive energy intake implicated in some and exonerated in others. Scragg *et al* suggest two explanations. Firstly, previous studies were too small and had methodological deficiencies. Secondly, their study showed high energy intake to be a risk factor only at younger ages. Indeed, at high energy intakes there was a