system]. I think this is overstated. While some patients may indeed be taken aback if they cannot see their own doctor Cartwright and Anderson[1] demonstrated several years ago that many do not mind and it may often be very valuable for a patient to meet a different doctor.

How can patients choose a doctor that suits them unless they can see several and choose? There are some group practices operating personal lists that actively discourage patients from changing to another doctor in the same group — such a policy is clearly aimed at the group of patients who 'work the system for their own purposes', to quote Dr Priestman, while others wishing to make an informed choice after meeting several of the partners are denied this possibility. Thus judgements have to be made about individual patients rather than standard policies applied to all. Unfortunately, this sort of decision cannot be delegated and inevitably doctors will be drawn into a dialogue with patients about the organization of the practice just as Dr Priestman implies in his last paragraph.

GEORGE K. FREEMAN
Primary Medical Care
Faculty of Medicine
Aldermoor Health Centre
Aldermoor Close
Southampton SO1 6ST

Reference

1. Cartwright A, Anderson R. *General practice revisited.* London: Tavistock, 1981: 23.

Video recording in general practice

Sir,

Our study of the recognition of depression in general practice sponsored by the Mental Health Foundation is the multicentre study mentioned by Dr Roberts in his letter (March *Journal,* p.134). We wish to clarify any misconceptions about our methods and to report our rates of patient refusal to video taping of their consultations for comparison with those of Servant and Matheson (December *Journal,* p.555).

Our methods conform to the requirements of the Wandsworth district ethical committee. A research psychologist (H.M.) speaks to every person before they see the general practitioner being video recorded. The purpose of the study is described, the video taping procedure is explained, and what the tape is used for is described as well as who will view the tape. The patient is then given a consent form and left to decide not only whether to consent but how to complete it. The form allows the patient to choose how any recording will be used and emphasizes that refusal to be video taped will not affect their general practitioner's willingness to see them. They are informed that the tape will not be studied within 48 hours of recording and that its erasure can be requested during that period with confidentiality still guaranteed. Notices are placed in the waiting room, the purpose of which are to prevent anyone being called prematurely into the consulting room without prior knowledge of the camera's presence.

Our intention is to have a well-informed, willing partner in our research. This is particularly important since patients are also asked to complete the 30-item general health questionnaire and may later be asked to agree to a lengthy interview, usually in their own home, by a research doctor (A.T.). Our method affords a stark contrast to that described by Servant and Matheson, which used minimal personal contact. Interestingly, they noted that consent was increased if there was some personal contact between patient and receptionist. Our refusal rate (Table 1) has been 5.2% when a notice is present in the waiting room and 6.2% without a notice. The findings are only preliminary: however, they are encouraging for others considering such research.

ANDRE TYLEE
HEATHER MAUGHAN
PAUL FREELING

Department of General Practice and Primary Care
St Georges Hospital
Blackshaw Road
London SW17

Table 1. Proportion of patients refusing or agreeing to video recording according to whether a notice was placed in waiting room (number of doctors = 22).

	Number agreeing	Number (%) refusing
With notice	997	55 (*5.2*)
Without notice	209	14 (*6.3*)

GP registration among homeless people

Sir,

As one of the two salaried general practitioners employed in London to provide primary health care to homeless people, I would agree with many of the points made by Toon and colleagues (March *Journal,* p.120).

I too have been looking at the registration details of the patients I see, but have asked those who said they were not registered if they had in fact tried to do so.

Of 205 consecutive new homeless patients seen between January and March 1987, 75 (36.6%) are registered with general practitioners (46 in London, 29 elsewhere; 95 (46.3%) are not registered; and for 35 (17.1%) I have no information about registration. Of the 95 not registered, 47 have not attempted to register and 10 have attempted to do so but were all refused (no information for 38).

I have attended a number of meetings on the problems of homeless people, and the difficulties in gaining access to primary care have tended to dominate discussion periods. My findings, however, show that only 22.4% of all the patients are actually registered with a general practitioner in London, and of those not registered at all, very few admit to having tried. Unfortunately, to our profession's shame, all those who did try were refused. These figures suggest that we need to try to increase registration of homeless people with local general practitioners and to monitor carefully the problem of refusal.

Finally, I wholeheartedly agree with Toon and colleagues' comments on the inaccurate stereotyped images of homeless people. Since taking up my present post I have found that, as a group, my new patients are among the most grateful I have ever treated.

GORDON A. LITTMAN

Primary Care for Homeless People
Bloomsbury Project
92 Chalton Street
London NW1 1HJ

Long term benzodiazepine use

Sir,

The paper by Salinsky and Doré (May *Journal,* p.202) argues that long term benzodiazepine users are a distinct sub-group of the population because they record higher scores on the Crown–Crisp index than matched controls. The authors state that 'The suffering is unlikely to be the consequence of their reliance on tranquillizers as dependence produces symptoms only when the drug is withdrawn', but produce no evidence for this. The implication seems to be that development of a withdrawal syndrome is the only way in which long term benzodiazepine use could affect the mental state of the user. This is very far from the truth and ignores much published evidence to the contrary. Chronic use has been shown to cause depression, paradoxical increase in anxiety levels, endocrine effects[1] and personality changes.[2] Most people who have helped patients to come off long term tranquillizers will have personal experience of the often dramatic changes in personality which can occur.