months, reached very different conclusions about associated characteristics.[1] Perhaps caution should have been displayed in discussing the Manchester results.

Although routine referral data provide no basis for an outsider to make judgements, there is no reason why every practice interested in this aspect of its work should have to collect the data for itself. Although we do not know why one doctor differs from another, there is no reason why a concerned practitioner should not be informed about how much he differs from the local average. Although Wilkin and Smith find it hard to think of ways in which the information could be used, this does not mean that others are not more imaginative.

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Reference

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Sir,

In the recent article on referral rates (August *Journal*, p.350) the authors found it difficult to come to any clear conclusion. I would suggest that one of the mistakes made was to measure referrals per 100 consultations. A general practitioner with a referral rate of 5% who sees 40 patients in a surgery would generate as many referrals as a doctor with a rate of 10% who sees 20 patients. It might be more appropriate to analyse referrals by list size.

In our first annual practice report I have given individual and total referrals per 100 patient years. This removes variations owing to individual consulting methods and it is a simple matter to divide the number of referrals per year by your list size and multiply by 100, although it would be difficult to measure variations between partners in a practice which does not have a strict personal list system. This system would however give a much clearer picture of trends, for example whether psychiatric referral rates were going up or down, as defined against a measured population rather than by the number of patients consulting.

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Sabbatical leave

Sir,

Dr O'Dowd's editorial (July *Journal*, p.290) will have stimulated many established family doctors to see which stage of burn out they have reached, and they may be wondering what they are going to do about it. Having identified and highlighted the problem, Dr O'Dowd did not go on to suggest options for resolving the problem. Entering the medico-political field, becoming a trainer or becoming involved in research are all feasible activities but the answer for many general practitioners is to take sabbatical leave from the practice for three to six months in order to undertake some different type of work or study.

Having recently enjoyed sabbatical leave myself, with the assistance of a Claire Wand Fellowship, I can thoroughly recommend the experience. However, it would be useful if the College had a package of information available to members who are considering sabbatical leave. At present the College library only has one article available (*Update* 1983; **27**: 795-797). The British Medical Association are only able to provide a copy of their *Notes on contracts for appointments overseas*, a list of overseas BMA branches and affiliated medical associations and some advice about work in South Africa, Zimbabwe and Saudi Arabia. While this information is useful, it does not help a doctor to plan sabbatical leave, with all its implications for his practice and family. Help is also required with contracts, references, employment agencies, work permits, and application for an educational allowance and a contribution towards the employment of a locum if prolonged study leave is being sought from the family practitioner committee.

Perhaps the accumulated experience of members who have taken sabbatical leave could be collated by the College for the benefit of those who are planning it.

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Health questionnaire

Sir,

The paper by Wallace and colleagues (August *Journal*, p.354) on health questionnaires in general practice prompts me to report our experience with a similar questionnaire designed by Anderson.[1] In January and February 1987, questionnaires were distributed in the waiting room of our urban practice in West Cumbria by our receptionists and 195 completed forms were collected; only one patient refused to answer the questions.

The practice has approximately 10 500 patients, mainly from social classes 4 and 5. There is a high proportion of council housing in the area and the unemployment rate is 18%. Ten patients failed to reveal their sex and among the remaining 185 respondents there were 67 men with a mean age of 47 years and 118 women with a mean age of 36 years.

Forty men (60%) and 47 women (40%) admitted to smoking; 19 men (28%) said that they had not taken alcohol in the previous month compared with 36 women (31%); 45 men (67%) had not been dieting compared with 74 women (63%); and 22 men (33%) and 40 women (34%) reported taking some exercise in the previous month. Although this was not a controlled study, several useful points can be raised. First, the smoking prevalence found is higher than class specific figures[2] especially among men, although men who smoke are probably over-represented in our waiting room. Secondly, there were more non-drinkers than expected.

Patients were interested in being asked about their health and lifestyle and were happy to answer questions. However, some elements of the questionnaire proved too complicated and to be useful as a health screening tool rather than a research device, a simpler section on drinking is needed. One approach would be to combine the CAGE questionnaire[3] with three additional questions: (1) On how many days a week do you take an alcoholic drink? (2) What sort of alcoholic drink do you usually take? (3) If beer, how many pints do you drink in an average session?

Despite some difficulties the questionnaire has given us a useful insight into our patients' habits and encourages us to include such enquiries in our consultations as opportunistic health screening.

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2. Office of Population Censuses and Surveys. *General household survey. OPCS monitor 85/2.* London: HMSO, 1986.
3. Mayfield D, McLeod G, Hall P. The CAGE questionnaire: validation of a new alcoholism screening instrument. *Am J Psychiatry* 1974; **131**: 1121-1123.