women and 32 men with an age range of 34 to 97 years (median 64 years). The length of time they had been taking benzodiazepines varied from 0 to 28 years with a median of 13 years. These patients were compared with matched controls.

The Wilcoxon test was used to compare the attendance rate of the two groups in the previous year and showed that those taking benzodiazepines attended more frequently ($P<0.001$) (attendance was not necessary to obtain a repeat prescription). The chi square test was used to compare a broad labelling of chronic illness, whether patients had seen a psychiatrist, whether alcohol abuse was noted and whether there was any evidence or suspicion of depression. Patients taking benzodiazepines had a significantly higher rate of chronic illness ($P<0.001$), psychiatric involvement ($P<0.001$) and depression ($P<0.001$) than the control group.

Using Prescription Pricing Authority information it was estimated that another 120 patients in the practice were receiving benzodiazepines on a long-term basis, thus giving a prevalence of 2.0%. This compares with 2.6% found by Simpson and colleagues and 1.6%[1] and 2.2%[2] found in other studies. Interestingly, that 23 of the controls had been prescribed short courses of diazepam in the past reflects the popularity of benzodiazepines in the late 1960s and 1970s.

The frequency at which prescriptions were issued revealed that many of the long-term users in my study did not take their drugs continuously. Simpson and colleagues state that 'the boundary between a benzodiazepine anxiolytic and hypnotic is not absolute in pharmocological terms or with regard to how the drug is administered'. In my audit I would have found it difficult to decide whether a patient was taking a hypnotic, an anxiolytic or an anxiolytic plus hypnotic. There may be variation between dosages and in the interval between doses in an individual patient who wants a day time anxiolytic effect one day and a nocturnal hypnotic effect the next. In addition, there may be increased use at times of crisis, and hoarding when times are better. What is written on the prescription and recorded in the notes may not represent what the patient takes. I expect this difficulty in allocation to groups is why it has 'not previously been addressed in the literature' and it is admirable that Simpson and colleagues were able to overcome this problem.

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References

1. Salinsky J, Dore C. Characteristics of long term benzodiazepine users in general practice. *J R Coll Gen Pract* 1987; **37**: 202-204.
2. Rodrigo E, King M, Williams P. Health of long term benzodiazepine users. *Br Med J* 1988; **296**: 603-606.

Health checks for infrequent attenders

Sir,

A number of points are raised by N F Thompson's paper on health checks for infrequent attenders (January *Journal* p.16). First, a number of patients did not return for tetanus vaccine or cervical smears. We have found it essential to encourage immediate uptake of these. Secondly, the health checks were performed only by the general practitioner. Using a practice nurse, particularly for cervical smears in the clinic, may have produced better compliance and also reduced the cost of the service. Thirdly, only allowing one hour per clinic must have produced a degree of stress in the participating doctor who would probably not be inclined to include other services on a 'there and then' basis.

At present we incorporate our infrequent attenders and new patients in our 'well-person checks'. Because a nurse is working during most of the doctors' surgeries the patient can choose a time to suit. An opportunistic 'Would you like a health check if the nurse is free?' from the general practitioner is another useful tactic.

We have an uptake of screening of 40% among patients invited and, interestingly, a number of patients respond to a second invitation. Cervical smear and tetanus uptake during the checks is over 50%.

Thomson's practice evidently has a high uptake of preventive services but we wonder whether a rethink or greater flexibility may help to improve the service beyond recognition.

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Efficient use of time in general practice

Sir,

I would like to support the conclusions of the editorial by Dr Roland (December *Journal*, p.485). We operate exactly the system of booking patients that he suggests and have done so for the last three years.[1] The system works well although our 'extras' usually fill up any available spaces, so that surgeries generally extend to three hours. However, the booked patients experience minimal delays with their appointment times and consequently the doctors feel less rushed. Our consultation rate is a little over three per patient per year and I am sure this system would work well in most general practice settings.

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Reference

1. Packham CJ. Appointment system or open surgery? *J R Coll Gen Pract* 1988; **38**: 568.

Sir,

Some readers may not have noticed the revolutionary implication of Dr Ian Hill-Smith's article on appointment interval (December *Journal*, p.492) and the editorial which refers to it (p.485). This is that the average time allotted to appointments should correspond to the average time actually taken by the doctor. There is a simple test of whether this extraordinary idea has been put into practice; this is to note the times at which booked surgeries finish. If this is more than 10 minutes later than the booked time more than one time in 10, there are exasperated patients, being calmed by harrassed staff, waiting to see a doctor who does not understand 'the efficient use of time in general practice'.

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Comparing trainer and trainee referral rates

Sir,

The comparison of referral rates among trainers and trainees described by Rashid and Jagger (February *Journal*, p.53) deserves further comment. They rightly conclude that such data need to be carefully interpreted, and I share their doubts that crude referral rates are a sensitive enough performance indicator for the purpose of resource allocation.

In any audit of rates, the importance of the denominator is axiomatic. With regard to referrals, rates based on the total number of patients at risk, that is the list size, may be just as valid as rates quoted with a denominator defined by number of consultations. It is unfortunate that the