Table 1. Responses to benzodiazepine dependency questionnaire.

	Number (%) of patients ($n = 44$)
Importance of medication for coping	
Vital/very important	36 (*82*)
Quite important	6 (*14*)
Not important	2 (*5*)
Concern about being on medication	
Not concerned/slightly concerned	39 (*89*)
Definitely/very much concerned	5 (*11*)
Perceived ease of stopping medication	
Very/fairly easy	12 (*28*)
Fairly/very difficult	31 (*72*)
Opinion about current medication dosage	
Extremely high	0 (*0*)
A little high	4 (*9*)
About right	36 (*82*)
Extremely low	4 (*9*)
Willingness to stop medication	
Very/fairly willing	18 (*41*)
Fairly/very unwilling	26 (*59*)
Feelings if medication were changed	
Not concerned/slightly concerned	30 (*68*)
Definitely/very much concerned	14 (*32*)
Feelings if medication were stopped	
Not concerned/a little concerned	9 (*21*)
Definitely/very much concerned	34 (*79*)

dosage as they have often altered their dosage to the lowest most appropriate level and regard it as 'just about right'.

Our results are in many respects similar to those of King and colleagues and we agree with their statement that 'patients who take benzodiazepines ... have a range of attitudes and responses towards the drugs'. We also concur with their recommendation that patients' views of their treatment should be an important consideration. Indeed general practitioners who have already encouraged their patients voluntarily to reduce to a minimum or stop medication are now faced with a more difficult task in managing the remaining group. A balance has to be struck between risk and benefit to the patient, which in the current climate of consumerism may be difficult to achieve. Nonetheless the risks, especially of falls in elderly patients, argue against a laissez-faire approach.

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Sir,

The paper by King and colleagues (May *Journal,* p.194) illustrates that patients must be given a choice in the matter of benzodiazepine prescribing, as in all other prescribing. Following the publication of the Committee on Safety of Medicines guidelines on benzodiazepine prescribing in 1989,[1] I set out to audit their use in my inner city single-handed practice with a view to rationalizing and reducing prescriptions. I saw all benzodiazepine users in the practice and gave them a choice: to slowly withdraw their tranquillizers under supervision or continue as before. I had two reasons for doing this. First, I wanted to concentrate help on those motivated to reduce or stop. Secondly, with regard to the medicolegal aspects of long term benzodiazepine prescribing and reports[2,3] of the possibility of litigation in this area of medicine, I considered that if every benzodiazepeine user were seen, advised and offered help, none could later complain about indiscriminate long-term prescribing.

Every patient prescribed any benzodiazepine during a three month period was interviewed, thus catching every known user. The patient was advised that current medical opinion did not favour continuation of such treatment and I was therefore offering to assist them in attempting to phase out the drug.

If the patient chose to continue, the prescriptions would be issued as before, and the outcome was recorded in the notes.

A total of 159 benzodiazepine users were identified (7% of the practice), of whom 105 (66%) were aged over 65 years and 37 (23%) were men. Thirty-three (21%) managed to reduce or stop benzodiazepines in three months, and the remainder either continued as before (72%) or increased their intake (8%). Of the 114 who chose to remain as before, 85 (75%) were aged over 65 years and their most frequent comment was 'why bother changing at my age?'

Thus in my small survey, most patients who were given the choice of supervised withdrawal or continuation preferred to continue taking their benzodiazepines, particularly those aged over 65 years. This implies that many patients taking benzodiazepines are either content with their drug use or cannot contemplate withdrawal because of their circumstances, even when other methods of relieving anxiety and insomnia are available. For prescribing doctors, if the choice of reduction and withdrawal has been offered to the patient and then refused, future patient dissatisfaction with long term prescribing should be less likely.

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2. Smyth E. Tranquillisers which destroy your peace of mind. *GMSC News Review* 1988; October: 11.
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Out of hours care

Sir,

I would like to make some comments in the light of the very interesting paper by Perry and Caine (May *Journal,* p.194).

The practical consideration of returning to the surgery does I feel largely rule out any general usage of the medical records in out of hours care. In a major emergency such as asthma or heart attack the doctor would indeed be negligent if he or she delayed arrival in order to hunt for the patient's notes. Furthermore, where a rota is in operation, I feel many doctors would not be happy for members of other practices to rummage around at night in their premises.

The only solution to this problem would of course be for patients to keep their own notes, and I have worked with just such a system. Unfortunately, it seems unlikely that this would be generally acceptable in this country. If and when patient-retained 'credit card' records are available then the problem may be solved.

Many doctors, however, seriously question the relevance of patient records in the emergency situation. I did a brief study of 300 consecutive out of hours calls and came to the conclusion that 80% of cases were acute self-limiting conditions unrelated to any previous medical condition. A further 18% related to an ongoing medical problem, details of which I could obtain from the patient and a