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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References

1. Committee on Safety of Medicines. *Current Problems* 1988, no. 21.
2. Smyth E. Tranquillisers which destroy your peace of mind. *GMSC News Review* 1988; October: 11.
3. Ashton CH. Dangers and medico-legal aspects of benzodiazepines. *Journal of the Medical Defence Union* 1987; 3: 6-8.

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

perusal of medicine bottles and repeat prescription cards. In only 2% of cases was there any difficulty and even in these cases it was possible to provide adequate emergency care based on clinical findings at the time. From a practical point of view therefore, general practitioners and deputies alike can manage perfectly well without seeing the records in approx 98% of emergency calls.

On the subject of continuity of care I think it is important to point out that the provision of continuity in out of hours care is not the prerogative of the group practice. Some of us who work as full-time deputies can claim continuity ratings roughly comparable. My own figures might be of interest. A study of 300 consecutive calls showed that I had recollection of previously visiting the homes of no less than 36% patients seen. Were I to repeat this study now that I have been nearly nine years in my present post, then I would anticipate a figure in excess of 40%.

Continuity is simply a reflection of time in post and the number of doctors providing the service. Obviously lower ratings would be recorded by those services employing large numbers of casual deputies, just as would be the case where calls were seen by trainees, new partners, locums and those from other practices working a large rota. There really is no difference.

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Surveillance of the over 75s

Sir,

Paul Wallace's editorial on surveillance of over 75 year olds (July *Journal*, p.267) was most discouraging as it was based entirely on theory and selected references. Doctors are not well served by the current negative thinking about reorganization, as this leads only to further discouragement.

I was glad he considers the eight parameters for surveillance, which I put forward to the RCGP in January 1988, to be appropriate. However, he then erects a number of barriers based upon theory, and not experience. Let us consider first the problem of intrusion into a patient's privacy. Such a phrase implies a barren doctor–patient relationship. My own experience of assessing over 70 year olds in my practice indicated that the older the patient the more likely it was that my visit would be welcomed. With the 30% of patients who lived alone, the difficulty was in ensuring that the visit had a medical as well as a social content. Wilkin and Williams'[1] excellent study of 17 771 consultations with patients aged over 65 years undertaken by 201 general practitioners showed that the mean time spent with each patient per year was 25 minutes divided between about five consultations — possibly not long enough to deal with complex medicosocial problems. My own figures showed that before my screening programme there were 6.6 consultations per patient per year in the 70 years and over age group. This figure fell to 3.8 in subsequent years so not only was much time saved, but the frustration of random symptom-oriented visits was avoided.

Dr Wallace quotes data from specialists which suggest that the full assessment would take 60–90 minutes. I found that, with practice, my examination took 20 minutes per patient on average, and was fully structured to geriatric anatomy and pathology. A standardized recording form is helpful both as an *aide-mémoire* and for research — my record had space for identification data by the receptionist, the doctor's examination, the social worker's or rehabilitation officer's home assessment, and the nurse's record of urine results, blood tests and blood pressure.

Dr Wallace considers it unlikely that any other member of the existing primary health care team will have time to take on the additional workload. In my practice we were perhaps fortunate in that senior nursing officers knew of our programme, and appointed appropriate personnel. In addition, time devoted to home confinements in the past became available as this work became hospital oriented. The district nurse and I often visited together to plan future management with patients, having found case conferences to be a time-wasting autocracy without the patient's presence. Such joint visiting still seems to be a rare practice.

So far as materials are concerned, I have made my record system available for many years. However, the RCGP has now produced a screening record card for the elderly.

When Dr Wallace suggests the need for training in the appropriate use of instruments and record forms I assume that he does not mean for general practitioners but for 'link workers'. However, the use of link workers would once more push the elderly to the back of the queue. The differences in doctors' perception of their role, result in a wide variation in the pattern of care provided for older patients. Many doctors still recoil from the social dimension needed in geriatric practice. Without this, however, practice would be very dull.

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Reference

1. Wilkin D, William EI. Patterns of care for the elderly in general practice. *J R Coll Gen Pract* 1986; **36**: 567-570.

Involvement of clergy in patient care

Sir,

It was refreshing to read the report by Ward Jones (July *Journal*, p.280) concerning the attitudes of general practitioners to the involvement of the clergy in patient care. Although the paper is a welcome contribution to this neglected area of study, the method used is somewhat unsatisfactory.

The principal difficulty is the use of the word religious without any definition being offered. The use of a letter from the Bishop of Bristol's advisory group in the study implies that the study was cast within a Christian context. However, given that the survey was located mainly in the city of Bristol, one can safely assume that many of the general practitioners and the patients they treat would belong to other religious groups. This factor, we believe, would have affected both the response rate and the answers received. Although the author may have wished to set the study in a Christian context, lack of data on the beliefs of the doctors themselves adds to the confusion.

Again, little distinction was drawn between religious practice and spiritual belief. This undervalues a spiritual belief whereby a person may not adhere to any particular religious practice but, nevertheless, may search for existential meaning within the experience of illness. This is not a minor quibble; some form of spiritual belief is much more common in the population than religious practice. It is a pity that no attempt was made to determine whether the general practitioners understood this distinction and how it might have related to their willingness to refer patients to the clergy.

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Budget holding

Sir,

Not being a member of the RCGP I obviously have little to lose from Dr Sykes' recommendations (April *Journal* p.170). However Dr Sykes has obviously not considered the future of general practice in