uninterested. However, 53% indicated they would use such a hospital if provided, 29% would probably or possibly use it and 18% would be unlikely or very unlikely to use it. No correlation was found between doctors' age, sex or practices fundholding status and level of interest. Use of community hospital as an out-of-hours centre attracted the support of 83% of doctors.

Of all 72 general practitioners, 78% indicated they would admit patients to an urban community hospital for respite care (82% of the 38 general practitioners who had reported they would use a community hospital); 75% of all doctors indicated they would admit patients for social reasons (74% of 38 doctors); 64% of all doctors would admit elderly acute medical patients (79% of 38 doctors); 60% would admit patients for observation, assessment and simple investigation (77% of 38 doctors); 50% would admit early hospital discharges following surgery (56% of 38 doctors); 50% would admit patients for terminal care (59% of 38 doctors); and 47% of all 72 doctors would admit early hospital medical discharges (56% of 38 doctors).

The high response rate reflects the relevance of the topic, although only half (49%) of general practitioners were in favour of a community hospital. They proposed positive primary health care reasons for their support, for example respite care. Therefore, such a hospital may attract different patients than are currently admitted to district general hospitals. The high proportions of general practitioners stating that they would use a community hospital for social and respite care suggest that these are not readily available at present, and indicate that community services are underused or perhaps underprovided. However, where a community hospital is to be built, a firm admission and discharge policy would need to be maintained to ensure appropriate bed usage.

An urban community hospital would provide services not now available, rather than being an alternative to district general hospital admission. This means that relatively small savings of bed days in a district general hospital could be anticipated.

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References

1. Victor C, Nazareth B, Hudson M, Fulop N. The inappropriate use of acute hospital beds in an inner London district health authority. *Health Trends* 1993; **25:** 94-97.
2. Coast J, Inglis A, Morgan K, *et al. The hospital admissions study. Final report* Bristol: Health Care Evaluation Unit, University of Bristol, 1994.
3. Baker JE, Goldacre M, Gray JA. Community hospitals in Oxfordshire: their effect on the use of specialist inpatient services. *J Epidemiol Community Health* 1986; **40:** 117-120.
4. North N, Hall DJ, Kearns W. First year of an inner city general practitioner hospital. *BMJ* 1984; **288:** 1209-1211.
5. Victor CR. End of an experiment: report from an inner city community hospital. *J R Coll Gen Pract* 1988; **38:** 407-410.

Reducing benzodiazepine usage

Sir,

Having read the paper by Cormack and colleagues on reducing benzodiazepine use among patients by sending them a simple letter,[1] I performed the same exercise on my own list of patients who regularly used benzodiazepines, after first screening out those I considered to be unsuitable for the intervention.

I undertook this exercise in February 1994 and, on review in January 1995, I found that the number of regular users of benzodiazepines has been reduced from 108 to 94, some 13%, with very little extra work and mainly positive feedback from patients. This result is confirmed from prescribing analyses and cost (PACT) figures and repeat prescribing computer analysis. My practice partners' benzodiazepine prescriptions have been static over this time.

As a result, we are extending the letter to include all regular benzodiazepine users in the whole practice of 11 500 patients.

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Reference

1. Cormack MA, Sweeney KG, Hughes-Jones H, Foot GA. Evaluation of an easy, cost-effective strategy for cutting benzodiazepine use in general practice. *Br J Gen Pract* 1994; **44:** 5-8.

Bereavement care

Sir,

Following the publication of the paper by Robinson and Stacy on setting guidelines for palliative care,[1] the question of bereavement care was addressed at a primary care team meeting in the practice. Three areas of interest arose out of the discussion.

First, attention was focused on those who had recently been bereaved. Should they be offered a visit, and if so by which member of the team? After a death, when would be the best time to visit a bereaved person? Should such people receive a booklet with information on death and grief? This produced lively dialogue, but no consensus. Therefore, following the meeting, the number of deaths over the last year was extracted from the practice computer. In a practice population of 12 000 there were 95 deaths. In 40 cases there was no identifiable survivor. Of the remaining 45 cases, a doctor or nurse had made contact with 37 survivors since the patient's death, and knew of their progress, leaving eight whose progress was unknown. It was decided to repeat the exercise every six months in order to examine the care that was being offered, and to develop a protocol.

Secondly, it was sometimes found that a patient's current problem was related to past, unresolved grief. Such revelations usually came towards the end of a consultation, when there was little time to explore the issues adequately. There was a need for a counsellor to take quick referrals. Each patient could be limited to four one-hour sessions over four weeks. From special family health services authority funds a bereavement counsellor was employed, and saw five patients in the first month. All were seen within 10 days of referral, and each stated it was of great benefit.

Thirdly, it became obvious that we as health professionals were not at ease with death. Education and training in grief was considered to be the most effective way of improving the bereavement care of patients. This suggestion was warmly received by all staff, and dates were arranged for training sessions.

Where there is enthusiasm and goodwill in a primary health care team, improvements in bereavement care can be initiated, with the benefit of helping both patients and the team.

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Reference

1. Robinson L, Stacy R. Palliative care in the community: setting practice guidelines for primary care teams. *Br J Gen Pract* 1994; **44:** 461-464.