practitioners is quite correct. For several years in South Africa we in the Cape Town private sector have operated a voluntary and much less labour intensive peer review system with a view to negotiating higher consultation fees in return for reduced costs. Because about 50% of the medical funds' expenditure goes on pharmaceuticals, and because prescribing habits are easy to monitor, we have concentrated on drug costs.

Dr Welsby suggests that his proposed system would have detected much earlier the unprofessional habits of the late unlamented Harold Shipman. I would suggest that the current systems should have exposed him much sooner.
I understand that Shipman was murdering his patients using heroin — which he was presumably getting from the local pharmacist or wholesaler. Why did the supplier of the heroin, and the NHS clerk who paid the accounts, not realise that Shipman was using more heroin than all the other area doctors combined?

Some years ago while doing the peer review at one of our emergency departments I spotted a previously unrecognised pethidine addict by the simple process of looking at the dangerous drugs register. He was prescribing more pethidine in a day than the other doctors in a month.

Simon A Craven
24 Kemms Road, Wynberg 7800, South Africa
E-mail: sacraven@mweb.co.za

REFERENCE

1. Welsby P.D. If Big Brother is to assess me, I want it to be my Big Brother. *Br J Gen Pract* 2006; **56:** 887.

Z-drugs

The two papers in the December issue of the *BJGP* on benzodiazepines and Z drugs are a timely reminder of the continuing (and, in my view, unacceptable) disparity between evidence and practice in primary care across the UK.[1,2] That such attitudes towards these drugs persist is quite astonishing.

Concern over the use of these drugs was highlighted by the Committee on the Review of Medicines as far back as 1980.[3] This concern led to the production of guidance on the use of benzodiazepines by the Committee on Safety of Medicines in January 1988,[4] advice that was backed at the time by the RCGP and the Royal College of Psychiatrists. There is every reason to believe that this guidance should be extended to cover the Z drugs.[5]

There is now very real concern that chronic benzodiazepine use may result in permanent cognitive impairment.[6] This, of course, may have legal as well as clinical implications for primary care physicians.

GPs in the UK pride themselves on their independent status within the NHS but this status cannot, and should not, be used as an excuse to continue to practice in the face of overwhelming evidence to the contrary. Failure to address these quality disparities really does bring our profession into disrepute.

Stephen McCabe
Portree Medical Centre, Portree, Isle of Skye IV51 9PE

REFERENCES

1. Vicens C, Fiol F, Llobera J *et al.* Withdrawal from long-term benzodiazepine use: randomised trial in family practice. *Br J Gen Pract* 2006; **56(533):** 958–963
2. Siriwardena AN, Qureshi Z, Gibson S *et al.* GPs' Attitudes to benzodiazepines and Z drug prescribing: a barrier to implementation of evidence and guidance on hypnotics. *Br J Gen Pract* 2006; **56(533):** 964–967.
3. Committee on the Review on Medicines. Systematic Review of Benzodiazepines'. *BMJ* 1980; **280(6218):** 910–912.
4. Committee on Safety of Medicines. Benzodiazepines, dependence and withdrawal symptoms. *Curr Probl* 1988; **21:** 1–2.
5. Jones IR, Sullivan G. Physical dependence on zopiclone: Case Reports. *BMJ* 1998; **316(7125):** 117.
6. Tata PR, Rollings J, Collins M, *et al.* Lack of cognitive recovery following withdrawal from long-term benzodiazepine use. *Psycholog Med* 1994; **24(1):** 202–213.

An overstated case?

Siriwardena *et al*[1] in their article move from their initial assertion of a 'lack of evidence distinguishing short-acting benzodiazepines and the newer Z-drug hypnotics' in their introduction; to an implied assertion in the title of their article and in the paragraph 'how this fits in' that there is evidence that there is no difference. A lack of evidence is not the same as evidence of no difference.

Indeed the NICE appraisal[2] of this subject pointed to a need for research in this area, and also highlighted the reality that it was unlikely to occur.

In pharmacology training doctors are taught about half-lives, this was the argument put forward in the past for using less of, for example, nitrazepam as hypnotics. Z-drugs have significantly shorter half lives than short-acting benzodiazepines, it is not surprising then that GPs believe that Z-drugs cause less 'daytime sleepiness/sedation'. In situations where evidence is lacking doctors will be influenced by guidelines, by their own experience, by their understanding of pharmacology, and, yes, by those who seek to influence their prescribing.

While it is true that the trend in hypnotic prescribing is not evidence based, it is not true that it goes against the evidence. The evidence is simply not there. This is an important axiom in evidence-based medicine.

Jean McClune
GP, Skegoneill Health Centre, Belfast
E-mail: jmcclune@ehssb.n-i.nhs.uk

REFERENCES

1. Siriwardena AN, Qureshi Z, Gibson S, *et al.* GPs' attitudes to benzodiazepine and 'Z-drug' prescribing: a barrier to implementation of evidence and guidance on hypnotics. *Br J Gen Pract* 2006, **56(533):** 964–967.
2. National Institute of Health and Clinical Excellence. *Guidance on the use of zaleplon, zolpidon and zoliclone for the short-term management of insomnia.* Technology appraisal guidance 77. London: NICE, 2004.