

We do, however, disagree that the management we advocate is to 'get out and exercise'. This is a common misconception. Cognitive behavioural therapy is not exercise therapy, and we are not physiotherapists. It is true that in the later stages of treatment patients are encouraged to increase their activity (which must ultimately be the aim of any treatment) but therapy does not involve the simple prescription of set amounts of exercise. Instead, treatment is based on mutually agreed targets, which are themselves jointly chosen as being some activity that the patient wishes to undertake, but has avoided. In practice this may simply be brushing one's teeth, or sitting out of bed to eat a meal. The behaviour is chosen solely on the basis of avoidance; the physiological and ergonomic consequences of such activity are irrelevant. The aim is to introduce predictability, and the return of self-control and self efficacy, not to restore muscle power. Furthermore, the other important component of our approach to management is an awareness of emotional disorders, and a recognition that these may need treatment in their own right.

We agree that the management we advocate is neither new nor unique. Almost identical management is now the treatment of choice for chronic pain⁵ and fibromyalgia.⁶ The latter is particularly relevant, since it is increasingly accepted that fibromyalgia may indeed be the same condition as post-viral fatigue.⁷ Furthermore, it is difficult to think of a pathological mechanism by which gradual increased activity could be harmful,^{8,9} even in the minority of patients with clear cut neuromuscular pathology.

The final decision must be based on evidence. We have already announced preliminary details of a pilot evaluation of cognitive behavioural therapy (Wessely S, *et al*, abstract presented at the scientific meeting of the Royal College of Psychiatrists, London, 25 September 1989). Our conclusion was that the advice currently offered to these patients may not be accurate, and that the current therapeutic nihilism in this condition may be unduly pessimistic.

In summary, the differences between our approach and that of Dr Ho-Yen may be less marked than at first sight. Given the difference in our samples and clinical experience, one might summarize by saying that whereas Dr Ho-Yen correctly emphasizes the dangers of doing too much, too early in the natural history of the condition, we emphasize the equally damaging consequences of doing too little, too late. The most appropriate strategy

depends upon the stage of the illness reached by the patient.

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Advising patients on their benzodiazepine use

Sir,

We read with interest the paper by Cormack and colleagues (October *Journal*, p.408) on the subject of advising patients on their benzodiazepine use. We have obtained comparable results from a similar, but not identical, study which we have just completed. In our prospective study in an inner city practice of 12 100 patients we identified 46 patients (0.4%) who were receiving benzodiazepines on repeat prescriptions. All were long-term users, the mean duration of use being 14 years (range three to 21 years), and they were an older group than that studied by Cormack and colleagues with a mean age of 62 years (range 30 to 89 years).

In their paper Cormack and colleagues noted that strategies used by patients to reduce benzodiazepine consumption were 'vague and unsophisticated'. We offered a simple programme to all our patients.

Intervention consisted initially of ceasing all repeat prescribing of benzodiazepines and instituting regular consultations for all those individuals wanting such medicines. At these consultations the patients were given verbal and written information about the known risks of long-term benzodiazepine use, and were offered a phased withdrawal programme involving dose reduction, reduced frequency of use and reduction in preparation potency, prior to cessation of all use. Progress was reviewed at subsequent consultations, and counselling support was offered within the practice (by practice counsellors) and outside the practice (in health authority clinics), although no patients took advantage of these options. Therefore, this strategy, while involving extra consultation time and the preparation of simple written material, used only resources available to all general practitioners.

One year after this intervention, six of the 46 patients (13.0%) had stopped all benzodiazepine use, 22 (47.8%) had reduced their consumption and 14 (30.4%) had not changed their pattern of use. No patients had increased benzodiazepine use, but two had left the practice and two had died.

Although this intervention was applied to an elderly subpopulation that we presumed would resist reduction of their benzodiazepine use, the success in changing habits was greater than anticipated. The assumption that such patients are 'hopeless addicts' appears unfounded. Formal challenge, the provision of verbal and written information and regular follow-up consultations seems a clear and effective strategy for approaching the problem of long-term dependency.

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Traveller gypsies

Sir,

I read with interest the recent review article on traveller gypsies and primary care (October *Journal*, p.425). While it covered many of the issues about travellers and health care, there are several further points that I would like to raise.

First, the review suggests that epidemics of infectious diseases have not been documented among the traveller popula-

tion. This is not correct as regards polio. In the last documented outbreak in England and Wales (1976-77) 26 cases of paralytic polio were recorded of which 20 cases were non-vaccine associated.¹ At least six of these were in gypsies who were unimmunized. It has been commented that 'the outbreak demonstrated that wild poliovirus could spread in well-immunized populations and cause paralytic disease in the unimmunized'.² In addition, low rates of documentation are likely to be due to reporting bias, for example when there has been an earlier unrecorded exposure to infections such as hepatitis A. Taken together it is most unlikely that the traveller population has lower rates of infection for many diseases than the settled population.

Secondly, the report makes little of the differences in culture and perspective which may help us to understand some of the reasons for conflicts and failures of communication between travellers and the health service. These differences can explain why travellers appear to be 'bad patients' and health care workers appear to be 'dirty' from the travellers' perspective.³ While different groups of travellers may vary in their outlook and the degree to which they accept the culture of the settled population, it appears that cultural differences, so often stressed as factors affecting difficulties of access to care for other ethnic minority groups, are less often considered for travellers. For example, different conceptions of cleanliness and dirt helps to explain the reluctance of some travellers to have their children immunized.

Thirdly, there are many practical problems that travellers may face in obtaining access to health care which are often not apparent from the perspective of settled populations. Lack of a postal address, geographical mobility, common family names and literacy difficulties all mean that appointments and information may not reach travellers and health education material may be inappropriate.⁴

By trying to understand the health service from the outside in rather than the inside out it may be that different problems, and hence different solutions will become apparent.

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How long should appointments be?

Sir,

I agree entirely with Dr Roland's editorial (December *Journal*, p.485) that consulting times are very variable, but I cannot agree that 'booking intervals of more than 10 minutes are incompatible with a list size of over 2000'. My list, in London, was near the national average of 2200 patients, and I booked at 15 minute intervals. In addition to these allocated times, I also held a surgery for quick consultations, without advance booking. This combination was popular, and the booked patients rarely had to wait for long.

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Incidence of pelvic inflammatory disease

Sir,

Avonts and colleagues (October *Journal*, p.418) misquote the incidence of pelvic inflammatory disease after insertion of a copper intrauterine device reported by my colleagues and me.¹ We were quoted as having reported incidences of 15.5 and 1.5 per 1000 woman-years for nulliparae and multiparae, respectively, thus suggesting that the incidence was some 10 times higher for nulliparae. Just the reverse was found. We reported 15.5 and 19.5 cases per 1000 woman-years for nulliparae and multiparae, respectively. The difference between the age-stratified incidences was statistically significant ($P < 0.05$).

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The spagyric art

Sir,

I agree with John Justice (Letters, November *Journal*, p.480) about the advertisement for 'spagyrik therapy' in the

Royal College of General Practitioners' *Members' reference book 1989*. I join with him in his protest about its inclusion. However, it has given me, and probably others, some mild entertainment and even a little instruction while browsing among books of reference.

'Spagyrik' is presumably from the obscure though historically correct word — 'spagyric' — pertaining to alchemy and probably invented by Paracelsus, a spagyrist being an alchemist, alchemy being 'the spagyric art' (*Shorter Oxford English dictionary* and *Brewer's phrase and fable*).

Paracelsus, who was born near Zurich, was of course 'the name coined for himself by Phillipus Aureolus Theophrastus Bombastus von Hohenheim (1490-1541) implying that he was superior to Celsus, the famous writer and physician of the 1st century' living in the time of Tiberius (see Lempriere's *Classical dictionary*). Brewer goes on to say that Paracelsus 'made many enemies owing to his disputatious temperament and flouting of academic traditions'. Douglas Guthrie, in *A history of medicine* (1945 edition, p.157), said that at Basel where Paracelsus was lecturer in medicine at the university, he 'allowed his intolerance to outweigh his discretion' — compounding his own medicines and vehemently condemning not only ancient writers but also the methods of his colleagues and contemporaries and publicly burning the works of Galen and Avicenna.

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Ill person clinics

Sir,

As it appears we are to be encouraged and possibly paid to set up various health promotion clinics under the new health service regulations, it occurred to me that a novel idea would be to set up an ill person clinic. This would target people who either were ill or perceived themselves to be ill and after the usual history taking and examination, advice would be given on how to improve their current state of health. I hope to attract health board funding for these clinics and with a bit of luck, I will be able to fit one or two of them in between screening clinics.

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