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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Temporary residents

Sir,

Temporary residents constitute a large additional workload for general practitioners, and many practices use assistants or locums during holiday seasons. The role of nurses in primary care has expanded over the past 10 years and yet best use is not always made of their skills.[1] As well as practice nurses, holiday camp nurses employed by some doctors and camps offer valuable advice and medical care to many holidaymakers and may help to alleviate some of the workload of medical practitioners.

The reasons for temporary resident consultations and the type of problems seen by practice or holiday camp nurses and general practitioners were assessed in a pilot study carried out by one practice in August 1992 in a semi-rural, holiday area. Over one week 80% of the 210 consultations with 195 patients were for acute problems which developed while the patient was on holiday. Of these 167 consultations, 78% were with a doctor; most consultations were for minor respiratory tract infections or minor skin or gastrointestinal complaints. The other consultations for acute conditions (22%) were dealt with by nursing staff and were mainly cases of trauma or miscellaneous problems for which patients themselves requested nurse attention. Twenty eight consultations (13%) were for chronic, ongoing illnesses, mostly related to cardiovascular, respiratory or genitourinary problems and 7% were for repeat prescriptions of drugs lost, left at home or depleted.

The consultations with nurses in this study were deemed appropriate to the skills available. Many nurses would like to extend their role and, with appropriate support and training, it should be possible for practice nurses to manage more conditions independently.[2] The report of the community nurse review recommended introducing nurse practitioners into primary care.[3] Training in history taking, diagnosis and treatment of specific conditions according to set protocols has been advocated[3] and such key tasks would provide a challenging and expanded new role for many nurses and enable them to manage far more consultations independently. Adequate training is mandatory but some general practitioners are reluctant to encourage their nurses in this direction.[4]

Nurse stations in holiday camps or on surgery premises for use by temporary residents may help to encourage patients to seek advice initially with a nurse practitioner who would either manage the patient or refer on to a doctor where appropriate. Use of protocols for the management of specific conditions such as gastroenteritis and upper respiratory tract infections as well as for the treatment of various problems such as sunburn, hay fever and insect bites would enable nurses to utilize their individual skills and should serve to limit the number of temporary resident consultations with medical practitioners.

Practice and holiday camp nurses provide a valuable service to holidaymakers and their roles should be encouraged and extended. Resources for further training, commensurate salary increases and extended medical insurance cover, as well as the support and cooperation of general practitioners who would themselves benefit must be provided before such changes can be considered.

KIERON COONEY

17 Melville Street
Ryde
Isle of Wight PO33 2AF

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Hypnotherapy

Sir,

It has been suggested that credible clinical trials of complementary medicine would carry weight in justifying meeting the costs of treatment from practice funds.

There is a considerable amount of literature on trials of hypnotherapy, particularly in stress related disorders. Perhaps the best documented area is in the treatment of gastrointestinal disease; in a series of papers on controlled trials of hypnotherapy in the treatment of irritable bowel syndrome both the efficacy and mechanism have been clearly demonstrated in severe, intractable cases.[1-4] At the end of treatment the symptoms of all 15 hynotherapy patients were mild or absent in comparison with the control group who showed only a small although statistically significant ($P<0.05$) improvement. Three years later these same authors reported on an 18 month follow up of the 15 patients, all of whom remained in remission, although two had required an additional session of hypnotherapy for a single relapse.[2]

In a trial of hypnotherapy in rapidly relapsing duodenal ulcer 30 patients were randomly allocated to treatment groups of ranitidine with and without hypnotherapy.[5] Twelve months after cessation of drug therapy only 53% of the hypnotherapy group had relapsed in comparison with 100% of the group not receiving hypno-therapy.

In a study of 30 patients with ulcerative colitis of more than five years' duration homogeneous groups were allocated to drug only and drug plus hypnotherapy treatment groups.[6] All of the patients in the hypnotherapy group were relapse-free over a period of 50 months while none of the control group showed any improvement. Inflammatory activity, number of stools and drug therapy were all reduced in the hypnotherapy group but not in the control group in which five surgical interventions were necessary.

Similar results have been demonstrated among patients with asthma, atopic eczema and psoriasis and in pain relief,[7-10] quite apart from hypnotherapy's applica-

tion in virtually all neuroses. I would suggest that there is sufficient evidence to justify the commitment of practice funds for hypnotherapy. Considering the morbidity and suffering affecting families as well as patients, the long-term drug treatment and/or the surgical interventions sometimes necessary in these disorders, it would appear to be mandatory to consider hypnotherapy.

Apart from the exceptional patient benefit in conditions responding poorly to previous conventional treatment, the saving of general practitioner and hospital outpatient consulting time, the reduction in expensive drug therapy and the reduction of admission, investigation and surgical rates must all represent an extraordinary potential for cost saving as well as a lessening of workload.

K D PHILLIPS

The P R P Clinic
97 Pinner Road
Harrow
Middlesex HA1 4ET

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Benzodiazepine super-abuse

Sir,
In recent years the trend towards an increasing misuse of benzodiazepines by young people in Scotland has been noticed, but official anxieties and new constraints seem to have concentrated on the intravenous abuse of temazepam capsules. Reports noting these include the update from the Advisory Council on Misuse of Drugs[1] and will no doubt be noted by the impending reports from the Scottish drugs task force and the Scottish home affairs committee report on misuse in Scotland.

Perhaps what is less well understood is the magnitude of the benzodiazepine taking by young people. More than injecting these drugs, oral abuse seems to be common, at least on the east side of Scotland. It is well known that people who have never injected drugs take large quantities of the commonly prescribed hypnotics. Our own experience of self-reported information by young people involved with prostitution, and others, is of doses ranging from 50 mg to 400 mg taken on a regular basis. Regrettably, a wide variety of benzodiazepines are used interchangeably. Recent experience has included some people topping these doses by taking up to 700 mg of diazepam at one time, and similarly massive doses of other benzodiazepines. Withdrawal fits are common.

An event validating these self-reported data occurred recently in the surgery. A young woman attending a regular appointment demonstrated dramatically the level of her dependence by producing 70 10mg tablets of diazepam, placing these in one hand, projecting them into her mouth and with a small sip of water swallowing the lot. She happily agreed to wait in the surgery under observation for several hours, and two hours later became impatient and insisted that she had things to do and would have to leave. At that time there was some objective evidence of slowing of decision making but no disorientation, no sign of serious sedation and a continuing ability to negotiate about her drugs prescription which included further benzodiazepines which 'she needed' for later that day. She was unconcerned about negotiating over her opiate habit which she considered to be mild at a mere 25 to 30 dihydrocodeine tablets per day. Followed up 48 hours later she was said by her boyfriend to be out at the shops trying to purchase some drugs.

Although this level of benzodiazepines or at least similar levels are often reported, they are equally often disbelieved by medical practitioners, including ourselves. This group of patients, however, seems to be on the increase and represents the 1990s wave of damaging drug use equivalent to what we saw in the 1980s with the heavy injecting. Treatment and solutions are not immediately apparent and I would be grateful for any helpful suggestions or comments.

J ROY ROBERTSON

Muirhouse Medical Group
1 Muirhouse Avenue
Edinburgh EH4 4PL

Reference

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Burnout

Sir,
I was most interested to read the editorial by Chambers on burnout.[1] I agree that the medical profession is better at recognizing that the problem exists than knowing what to do about it. Since the early 1980s I have been running groups for health professionals which provide an opportunity for busy clinicians to look at their own personal and professional problems in the hope of reducing their own stress and improving the service they provide to patients. A number of general practitioners have attended these groups and commented on them favourably; indeed, some have attended on a regular basis over a period of years. Weekend groups are held twice yearly in Bristol and there is a one week residential group in Devon in the summer. I should be happy to send further information to any readers who might be interested.

RICHARD TILLETT

Psychotherapy Department
Wonford House Hospital
Dryden Road
Exeter EX2 5AF

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Information feedback

Sir,
We read with interest the paper by Szczepura and colleagues on the effectiveness and cost of different strategies for feedback in general practice (January *Journal*, p.19). The authors conclude that their study provides valuable information on how centrally collected data might be used cost effectively to develop information feedback at practice level.

We work within a health commission which purchases health care on behalf of both the family health services authority and the district health authority and believe that health authorities have a duty to feed back to general practitioners information available to them from a variety of sources. Such information might facilitate audit and promote an improvement in the quality of services delivered in primary care.