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.

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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.

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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.

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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.

To this end we have developed an indicator package which draws data from the health services authority 'Exeter' computer system, the Prescription Pricing Authority, the child health computer and general practitioners' own practice reports and feeds back these data to all local practices using a software package similar to that used for the health service indicators. These indicators have been well accepted by general practitioners and have attracted a great deal of interest at all levels of health service management. We hope to develop the indicators further and share the package with other health authorities to enable feedback of vulnerable information to those who deliver primary health care.

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Screening patients for alzheimers disease

Sir,
I read with interest the paper by Wilcock and colleagues on detecting patients with alzheimers disease suitable for drug treatment (January *Journal*, p.30). Having screened 246 patients, the authors ended up with one patient who may or may not have derived benefit from drug treatment for alzheimers disease. On this basis they conclude that every patient aged 75 years and over should be screened annually.

The initial screening may well not be particularly onerous, but the follow up of abnormal test results would involve considerably more time, and even the basic level of five minutes per patient per year would mean an extra 20 hours of work, which would have to come from somewhere.

The benefits of all this hard work appear to be marginal. While I am in favour of improving the quality of life of elderly patients, I feel that blanket screening is not the best way of doing this. Surely it would be better to target those patients in whom there is some suspicion of memory loss or confusion? This would usually become apparent during the normal annual check for those aged 75 years and over.

General practitioners have come under a lot of pressure recently to perform screening tests on the general population of little or no proven value, at the expense of providing care for the sick: this is another example.

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Value of health checks

Sir,
The February *Journal* was interesting with two articles on health checks: the British family heart study and the accompanying editorial by Mant (February *Journal*, p.62 and 51, respectively). Neither demonstrate nor quote evidence of mortality reduction. The value of such approaches seems to be accepted for the reduction of risk factors rather than of risk. The deleterious effects of such interventions on the individual, the population and on the doctor now obliged to carry out such strategies are entirely ignored.

In my practice at least three patients resuscitated following cardiac arrest outside hospital have survived between three and 10 years. It does not require a trial to establish the benefits of such a strategy on deaths from coronary heart disease yet the Royal College of General Practitioners and the government continue to encourage and promote unproven risk factor reduction (not the same as risk reduction) strategies, often limiting personal freedom, and engendering guilt. These additional pressures from academia and politics sap both enthusiasm and resources from local initiatives which are self evident in their effectiveness.

In his editorial (February *Journal*, p.50) McCormick refreshingly points out that judgement should be applied to even the most straightforward clinical situations. One can only hope that common sense triumphs over dogma.

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Judgement in medicine

Sir,
We have been treated to an editorial by the doyen of personal care James McCormick (February *Journal*, p.50). Are his words the distilled wisdom of a sage, or is he simply wearing 'judgement' like the emperor who wore his new clothes?

He states that exercising judgement requires experience that is 'patient specific and relies on knowledge of the individual'. There have been sentiments similar to Professor McCormick's recently expressed in an editorial in the *British Medical Journal*.[1] While these add to our feel-good factor and to the mountain of soft data, they will fail to impress the masters of our health service, nor will they give much support for the promoters of personal care.

What is needed is hard debate with robust data to resolve the profession's most puzzling conundrum. This is the paradox of our creed of personal care, and our action of marching resolutely in the opposite direction.

The hard data we have show that the primary health service we provide is from increasingly large health centres, is increasingly complex both technologically and managerially, and increasingly anonymous. The evidence is that this trend is continuing.[2] This direction is driven by the Minister of Health, the Department of Health, supported by many leading general practitioner intellectuals[3-5] and has the tacit support of the Royal College of General Practitioners and the British Medical Association. Interestingly, perhaps worryingly, there is increasing evidence suggesting that patients do not share this enthusiasm (Thomas KJ, *et al*, personal communication).[6,7]

If personal care is important then how important, and how will we ensure its place in the future National Health Service? One major benefit of the resolution of this paradox would be that the profession will no longer seduce bright, caring, young people only to have them suffer emotional atrophy, disillusionment and burnout.

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