ment small and cheap—the size of the Wellcome Diary and costing about £50. Calculators such as the Sharp EL5100 have an alphanumeric display and probably sufficient memory and calculating power to perform electrocardiogram interpretation and to display the diagnosis. Additional plug-in modules might provide updated advice on treatment and a bubble memory could hold the basic signal which would be recorded on to paper by a conventional electrocardiograph machine on return to the surgery.

Although the demise of paper records in general practice seems certain, pie in the sky claims for computers fail to appreciate the size of the onerous task of transferring existing paper records into the memory of a computer. The use of a dedicated computer, in this case dedicated to the electrocardiograph signal, does appear to be a more attractive proposition, particularly in view of the large proportion of general practice which is taken up by cardiovascular diseases.

B. JAMES

Cherry Orchard
Marlow Common
Bucks.

MEDICAL RECORDS

Sir,

The article by Dr Roger Gadsby, "Recording information about immunizations" (July *Journal,* p. 410), is very important indeed. A few months ago I had a detailed questionnaire to complete about a patient who is being considered for compensation for brain damage due to immunization. It was a tedious job going through 15 years of case notes and illegible writing. There was just a mention of DPT, but no batch number or name of manufacturer.

Dr Gadsby is right to draw attention to the important point of 'over-immunization'. This can be avoided by proper recording of all immunization procedures.

FP7A and 8A seem to me to be out of date as smallpox is no longer being used. The spaces for DPT and other immunizations are so small that it is difficult to enter the batch number and manufacturer's name. The format needs to be reviewed, and there should be a space for comments, e.g. under pertussis one could write 'parents declined', or 'contraindications'.

Different manufacturers have different identification details: some say lot number, some say batch number, some say both, and it is difficult to know which one to record for future identification (perhaps in 15 to 20 years' time).

FP7A and 8A should be available as normal stationery supplies, so that details can be entered every time an immunization is done. On no account should the details be entered on continuous cards or anywhere else, as sometimes happens when notes are not available for children who are not registered or when waiting for records to come from the family practitioner committee. In Stoke-on-Trent, computer print-outs are sent with dates of immunization. I think the date should be entered on FP7A and 8A rather than the print-outs be filed, which makes notes bulky, but I do not see the batch number or manufacturer's name on these cards.

It is wishful thinking to suppose that patients would keep their own immunization record cards like passports or other valuable documents, but if they did, then the familiar jabs of tetanus at accident departments would not be so common.

Lastly, I agree with Dr Gadsby that no matter how much may be said about the shortcomings of the present record envelopes, at present they are still the proper place to keep patients' immunization details.

R. P. YADAVA

14 Merton Street
Longton
Stoke-on-Trent ST3 1LG.

Sir,

The editorial in the July issue of the *Journal* (p. 386) rightly emphasized the urgent need to reform medical records in British general practice. However, this and the following editorial on computers in primary care regrettably may well have encouraged delay in the improvement of medical records by failing to make the vital distinction between small dedicated computer systems designed for specific tasks and larger computers which attempt to store all information and replace the A4 folder. We must heed experts like Mr Brennig James, Lecturer in Electronics, London University, whose letter to the Editor (July *Journal,* p. 441) so clearly states the impracticability of large scale total computer data storage. I will give odds of 10 to one that less than five per cent of practitioners will be able to abandon paper records within the next 15 years.

I should be very interested to hear from anyone prepared to take me up on this offer. Otherwise I feel experts should concentrate on promoting the best available record system which, as all who have tried the system would agree, is an A4 folder system rather like that so ably described by Drs Marsh and Thornham (1980).

K. A. HARDEN

85 Milngavie Road
Bearsden G61 2DN.

Reference

Marsh, G. N. & Thornham, J. L. (1980). Changing to A4 folders and updating records in a "busy" general practice. *British Medical Journal,* **281**, 215-217.

THE JOURNAL

Sir,

In joining correspondence on the *Journal* may I add how great was my anticipation and pleasure in reading former issues of the College *Journals.*

After joining the College in 1959 I visited the original premises off Sloane Square and requested, and received, every back number of the *Journal.* These *Journals* to me often read like a novel, the articles being tales of discovery from general practice. Many of them, though, were more notable for their ideas and inspiration than for their substance. The current *Journal* contributions are certainly more disciplined and do contribute to the substance of general practice but the cost, I suspect, is that far more of a current issue remains undigested or, dare I suggest it, unread. Indeed, the practice manager no longer reads the *Journal.* Perhaps some auditing of readers would not be out of place?

In spite of the "editorial headache in keeping the balance", suggested by Dr J. S. Norell (September *Journal,* p. 567), contributions might be shared between those who write scientific, disciplined, and statistical material and those of us who, while not lacking in ideas, often lack the know-how and discipline to translate such ideas into substance.

Sir, whilst all roads lead to Rome, some travellers may prefer alternative routes.

DAVID RYDE

56 Anerley Park
London SE20 8NB.

Sir,

As a recent candidate for the MRCGP examination, I had cause to read through recent copies of the *Journal* with some care. I underlined in the list of contents on the front page those contributions I thought of immediate and practical interest as an examinee, and which were relevant to my work in general practice over the last seven years. In one third of the copies of the *Journal* I found nothing I considered worth underlining.

I do not think that record is good enough. Many of the contributions to the *Journal* are peripheral to the main business of general practice. I suggest that there should be a regular monthly article dealing briefly, trenchantly, but as comprehensively as possible, with one of the bread and butter topics of general practice, and that two pages should be set aside in the next *Journal* for correspondence arising from the previous month's article.

This is my bread and butter: the management of hypertension, all aspects of family planning, the normal development of the young child, asthma and chronic respiratory disease, depression, the child with recurrent earache, febrile convulsions, eczema, hayfever, insomnia and anxiety . . . and I have only just started. Many of these topics are covered very indifferently in general medical textbooks and textbooks of primary care.

A monthly review article of such a nature might provide a consensus view, perhaps with a touch of stimulating realism, on what we all actually do each working day. I do not require the kind of article which advises me to arrange an ECG or CXR on *all* hypertensive patients, or to take swabs from *all* children with sore throats. I do not do that, you do not do that, nor should any of us do that. What we would all like to know is what the good to middling working general practitioner, the general practitioner *moyen capable,* the general practitioner on the Clapham omnibus, *should* do.

JOHN MANTLE

12 Taunton Road
Bridgwater
Somerset
TA6 3LD.

BOOKLETS FOR PATIENTS

Sir,
I was most interested to read Dr L. A. Pike's article (September *Journal,* p. 517) on the use of health education booklets, but unfortunately I cannot share the enthusiasm expressed in the editorial of the same issue for the method used to study the effect of these, or for your assessment of the implications of the reported findings.

First of all, it is difficult to assess any of the marks shown in the results without any information on the possible total scores. However, even if we accept a significant increase in the experimental groups scores, by using the same multiple choice questionnaire only two to three weeks after the 'pre-test', there are possible explanations other than the booklet. Some of these could have been assessed if the 'control' group had been used as controls. In fact it is not clear why they were included since Dr Pike and his colleagues chose to use the experimental group as their own controls. Nevertheless, whatever method had been selected, surely a longer period than two to three weeks should have been chosen to test the effect, if any, of the booklets?

A more fundamental point not raised by Dr Pike in his discussion is: will increased patient knowledge necessarily reduce morbidity and mortality in the community? Health and illness behaviour are complex processes and we are unlikely to make successful advances in health education by oversimplifying them. Some of these complexities are discussed in the excellent article by Professor D. Morrell and his colleagues (1980) to which you referred in your editorial.

CHARLES B. FREER

Ruchill Hospital
Glasgow G20 9NB.

Reference

Morrell, D. C., Avery, A. J. & Watkins, C. J. (1980). Management of minor illness. *British Medical Journal,* **280**, 769-771.

TRAINEE GENERAL PRACTITIONER

No, Sir!
Were I aiming to become a general practitioner (or anything else demanding expertise), and had I, as a newly fledged doctor, the good fortune to obtain an apprenticeship to an experienced master in the discipline, I should find nothing derogatory in being called correctly a trainee (May *Journal,* p. 308 and September *Journal,* p. 568). The matter is more important than merely inventing imaginary difficulties when so many real problems challenge us. Our embryonic general practitioners are thus encouraged to scorn or discount the experience of others, and are tempted into the besetting sin of doctors of all sorts, namely a mind so closed by its own notions that it has become impervious.

Healthy scepticism becomes intellectual arrogance unless it humbly accepts and patiently sifts experience, our own and that of others. I should be less than happy to find myself the patient of a general practitioner who, at any age, was ashamed to be a trainee. If we are to become and remain good doctors we depend throughout our lives upon our willingness to be taught by the experience of others, especially that of our patients. The man who, at the outset of his career, is encouraged to resent the title of trainee, may grow into the doctor who is too arrogant to respect what his patients are trying to tell him, and too insensitive to take the time to win the reality of their experiences from the circumlocutions and misinterpretations in which they may be couched.

R. EDGAR HOPE-SIMPSON

Epidemiological Research Unit
86 Dyer Street
Cirencester GL7 2PF.

MANAGEMENT OF EPILEPSY

Sir,
The management of epilepsy in general practice is well described by Dr Ann Lloyd Jones (July *Journal,* p. 396), and we strongly support the emphasis she places on serum anticonvulsant measurement.

However, we cannot accept that patients should be said to have good control "if they had not more than three attacks a year". We feel this is a basic failure in treatment. Even a single fit causes considerable social repercussions, of which the prohibition from driving for the subsequent three years is the most easily identified. Since Dr Lloyd Jones' results were collected, Shorvon and colleagues (1978, 1979) have demonstrated that 85 per cent of newly diagnosed epileptic patients and at least 50 per cent of patients with previously poorly controlled epilepsy can be maintained free from fits by ensuring that the serum anticonvulsant levels are in the therapeutic range (up to the upper limit of the range, if necessary).

Poor patient compliance in taking anticonvulsants is frequently stated to be a major factor in the failure of treatment and Dr Lloyd Jones supports this view. There is no published evidence that this is generally the case. We have found that doctors prescribe anticonvulsants in amounts insufficient to achieve therapeutic serum levels and that the monitoring of serum levels is not yet part of the routine management of patients with epilepsy. In such a situation the responsibility for the failure of treatment cannot be ascribed to the patient.

P. T. WHITE
E. G. BUCKLEY

Howden Health Centre
Howden Livingstone
West Lothian
EH54 6BX.