

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.

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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.

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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 experi-

ence 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.

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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.

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