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.

References

Shorvon, S. D., Chadwick, D., Galbraith, A. W. & Reynolds, E. H. (1978). One drug for epilepsy. *British Medical Journal,* **1,** 474-76.

Shorvon, S. D. & Reynolds, E. H. (1979). Reduction in polypharmacy for epilepsy. *British Medical Journal,* **2,** 1023-1025.

Sir,

I was interested in, but not altogether surprised at, the findings of Dr Ann Lloyd Jones in her survey on the management of epilepsy in general practice (July *Journal,* p. 396).

Readers may recall she found 60 per cent of epileptics with serum anticonvulsant levels outside the therapeutic range and an alarming 62 per cent on anticonvulsant polypharmacy. Our own figures for epileptic patients attending the Clinic for Sexually Transmitted Diseases at Newcastle General Hospital are very similar. Surely these figures should give cause for more concern in the light of recent studies such as those by Shorvan and colleagues (1978), in which they concluded: "Anticonvulsant polypharmacy is often and possibly totally unnecessary in newly diagnosed epileptics." For those epileptic patients already on a cocktail of drugs Shorvan and Reynolds (1979) recommend "conversion to single drug therapy whilst carefully monitoring serum levels". In this series it is worth noting that 55 per cent of patients actually had an improvement in seizure control, whilst 17 per cent had some exacerbation.

With so many epileptics in the community, many of whom will be on treatment for life, surely we can give them a better deal. If neurologists claim that clinics are too busy and that they are unable to provide long-term follow-up, more encouragement should be given to general practitioners to take a more active part in the management of the chronic epileptic. Procedures such as modifying anticonvulsant therapy according to recent advances in therapeutics, discouraging the use of the older and more sedative anticonvulsant, such as 'Mysoline', and checking serum anticonvulsant levels should become routine when problems arise. This is especially important for drugs such as phenytoin with a low therapeutic ratio and an exponential dose/plasma level curve (i.e. small changes in oral dose produce a proportionately larger change in serum levels).

N. W. Doll

Newcastle General Hospital
Westgate Road
Newcastle Upon Tyne
NE4 6BE.

References

Shorvon, S. D., Chadwick, D., Galbraith, A. W. & Reynolds, E. H. (1978). One drug for epilepsy. *British Medical Journal,* **1,** 474-76.

Shorvon, S. D. & Reynolds, E. H. (1979). Reduction in polypharmacy for epilepsy. *British Medical Journal,* **2,** 1023-1025.

THE CONSULTATION

Sir,

In the papers by Drs N. V. Raynes and V. Cairns on the length of general practice consultations (August *Journal,* p. 496), two rather misleading references are made to the time study of consultations in general practice reported by Dr Buchan and myself in 1973. First, on page 246 it is said that we found no significant increase in time per consultation for "patients diagnosed as psychosomatic". Table 9 and Figure 5(c) in our report do show that consultations for psychoneurosis (ICD) averaged 0·3 of a minute more than the average of all consultations; moreover, the category of ill defined conditions which certainly contains some psychoneuroses (but otherwise labelled) averaged six minutes of face-to-face time. I suppose it all depends on what Drs Raynes and Cairns deem 'significant'.

A much more seriously inaccurate assertion on page 497 states that we did not confirm a relationship between increased age of patient and consultation length. Table 7 in our report shows that both crude and standardized consultation times did rise with age and the analysis in Table 8 shows some of the reasons for this.

So much for the evidence. Value judgements may be more suspect than of yore but I am bound to express surprise that researchers from a reputable institute should appear to be so careless in their reading of literature.

I. M. Richardson

University Department of General Practice
Foresterhill Health Centre
Westburn Road
Aberdeen AB9 2AY.

Reference

Buchan, I. C. & Richardson, I. M. (1973). *Time Study of Consultations in General Practice. Scottish Health Service Studies No. 27.* Edinburgh: Scottish Home and Health Department.

The above letter was sent to Dr Raynes, who replies as follows:

Sir,

Professor Richardson makes two criticisms of our paper (August *Journal,* p. 496). The first, as he points out (citing a wrong page number), depends on what is meant by 'significant'. In research papers written by sociologists and statisticians it is usual to reserve the term to mean statistical significance. That practice was adhered to in our paper. We are sure that most of your readers are accustomed to this. We should like to point out that reporting numerical differences, such as increases in length of consultation time related to other variables, without using statistical tests of significance, can itself be misleading.

As we point out in the last paragraph in our discussion section, there are problems of interpreting inconsistencies between results of studies in this field. This is largely because of the differences and difficulties generated by the classification of diagnoses in general practice.

The second error of which we are accused is contained in a sentence on page 497. The paragraph in which this sentence appears makes it clear that both the Scottish data (Buchan and Richardson, 1973) and Westcott's (1977) indicate a link between increased age and consultation length. Westcott's data, however, unlike that reported in the Scottish study, showed a consistently linear relationship between the two variables.

Norma V. Raynes
Senior Lecturer
Institute of Psychiatry

De Crespigny Park
Denmark Hill
London SE5 6AF.

References

Buchan, I. C. & Richardson, I. M. (1973). *Time Study of Consultations in General Practice. Scottish Health Service Studies No. 27.* Edinburgh: Scottish Home and Health Department.

Westcott, R. (1977). The length of consultations in general practice. *Journal of the Royal College of General Practitioners,* **27,** 552-555.

PRESCRIPTION ERRORS

Sir,

With reference to the article on prescription errors by Mr Austin and Mr Dajda (July *Journal,* p. 417) I can offer some even more bizarre mistakes made by relatives requesting repeat prescriptions for members of their families.

I have received: "Insulin A.T." (Sol. Insulin 80 units/ml), "Dorbanex 40" (Susp. Dorbanex Forte), and "Ventolin formula Grammes" (Ventolin 4 mg).

No doubt your readers have many others.

Ivor E. Doney

Hazeldene
Hazel Avenue
Chapel Green Lane
Bristol BS6 6UD.