between treated and untreated patients in learning behaviour or intellect, and seizure control was significantly improved in the treated group.⁷ A more recent survey of epileptic children in schools showed that those who were receiving phenobarbitone were achieving more educationally and had fewer behaviour problems than others who were not being so treated.⁸ Furthermore, no significant reduction was noted in the Wechsler Intelligence Scale for Children when this was administered at least eight years after a convulsion with fever to children who had received barbiturates for at least one year before the age of 7 years.⁹ On the other hand, a reduced verbal quotient was significantly related to recurrence of convulsions.⁹ It has been shown that it may not be possible to prevent all recurrences of febrile convulsions by the use of phenobarbitone in apparently "therapeutic" dosage,¹¹ but significant reduction in the recurrence rate has been achieved in a group of high-risk patients.¹²

Longer, better-controlled studies must surely be conducted before barbiturates are discarded in favour of less well-trying and possibly more harmful anticonvulsants.

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Erythema nodosum and brucellosis

SIR,—It is sometimes difficult to diagnose brucellosis. Dr R S Goldstein (3 April, p 809) considered that his patient with erythema nodosum had acute brucellosis because the agglutination titre to *Brucella abortus* was high and because the symptoms disappeared after 6 weeks' treatment with tetracycline. He had not recently left Birmingham, nor had he been in contact with livestock or unpasteurised milk. A man who had stayed in London permanently for 12 years, however, developed brucellosis, proved by blood culture. His employer had supplied the hotel where he worked with unpasteurised milk from his country farm.¹ Blood (or marrow) cultures are rarely positive in brucellosis,² and they were negative presumably in Dr Goldstein's case. Surprisingly, his agglutination test became negative within only 6 weeks. The histological lesions of acute brucellosis are indistinguishable from those of sarcoidosis³; moreover, in one case of sarcoidosis serum antibodies to *Br abortus* were present.⁴ *Br abortus* and *Yersinia enterocolitica* antigens are known to cross-react,⁵ and both the latter organism and the sarcoid agent may sometimes react with thyroid epithelial cells.⁶ The high immunity of sarcoidosis not infrequently induces false-positive immune responses. The tuberculous

phage appears to be involved in sarcoidosis,⁷ and it is also the bacteriophage specific for *Br abortus*.⁸ Because Dr Goldstein's patient had erythema nodosum he probably had sarcoidosis and not brucellosis. A Kveim test might still be diagnostically valuable to decide this point.

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Postgraduate medical education in the EEC

SIR,—Mr A J Rich is to be congratulated for collecting and publishing useful information on postgraduate medical education in four Common Market countries (24 April, p 1027). On one or two matters, however, he is guilty of error.

There are not three directives but two (75/362/EEC and 75/363/EEC). The idea of spending the preregistration year outside the graduate's home country is not specifically provided for in either of the directives but is the subject of a Council recommendation (75/367/EEC). This fact has particular importance in that whereas the directives are binding, recommendations are not.

It is not quite true, and may be misleading, to state that the effect of the directives is to standardise the length of undergraduate and specialist training. In fact the directives standardise only minimal lengths of training. Every country is free to exceed these, and many do. Finally, it is not quite true that specialist registration or the acquisition of a specialist diploma confers the right to undertake independent specialist practice. It may be perfectly legal to do this with a basic qualification alone. What is conferred is the right to use a title protected by law whereby both the public and the insurance organisation can recognise fully trained specialists. This is important for the public since they approach the specialist without any intermediary reference, and for the insurance organisation since they pay him at a higher rate than the non-specialist.

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Should doctors strike again?

SIR,—It is clear that our profession is heading for another confrontation with the Government. Already some of our colleagues have gone on strike and undoubtedly there will soon be calls for more widespread action. The great majority of doctors are opposed to the Government's proposed legislation to separate private practice from NHS hospitals. As the chairman of the BMA Council so rightly said (10 April, p 915), it must damage the NHS, the independence of the profession, and the freedom of choice of the patient.

It is a matter on which doctors feel passionately—but should we strike? We would urge most strongly that we do not. Striking is against the very nature and spirit of our work as a caring profession and forfeits the respect of society. It does not make sense to say to a patient, in effect, "I won't help you today because I want to be able to help you better tomorrow."

A number of leading members of the profession have admitted privately that they have had a strong urge to speak out against strikes during the past two years. They refrained from doing so because of their knowledge that in some areas doctors who were labouring under impossible burdens felt that nothing less than "industrial action" would impress the Government and the nation with their sense of despair. No doubt the strikes did draw attention to the grievances, but it was impossible to avoid giving the impression—albeit false—that the main concern was personal gain rather than a desire for a better Health Service.

What can we do? We believe that each of us should write to his member of Parliament, briefly stating his deep fears for the future of medicine in Britain and urging that this contentious and potentially damaging issue should be referred to an impartial body for a careful reappraisal. There is so much room for improvement in the NHS and doctors are more than willing to work for it—provided the future is not prejudged on the grounds of a political ideology. If in the end of the day the Government will not be dissuaded, they must suffer the inevitable consequences of a deteriorating service.

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Non-contributory invalidity pension

SIR,—I am more than concerned over the administration of the non-contributory invalidity pension (NCIP) which began in January this year. Certain individuals (mainly, it appears, in the mentally deficient category) who normally receive supplementary benefit are now apparently "entitled" to sickness benefit even though they have not paid any National Insurance contributions. I have found great difficulty in obtaining any information about this new legislation, and the information that I have is gleaned from more than helpful local DHSS staff. The medical profession appears to be the last to be informed about the new regulations.

I have been required to issue medical certificates certifying these patients' deficiencies on form Med 3 for a period of one year. This is completely contrary to the usual regulations as these patients are neither sick nor have been previously issued with certificates. I might add that I have remarked on the form, in order to cover myself, that I have modified it purely for the purposes of NCIP. I am also not aware whether providing these certificates is part of one's contractual duties or even if there is a fee to be paid.