**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).

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**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.

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**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.

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**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.

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