primary care team varies and we try to fit in with what they feel they can do. Experience has been gained in drug dosage in children and knowledge of the value of, for example, palliative radiotherapy as a better means of pain relief than opiates in certain specific conditions. Our community nurse liaises with the primary health care team in caring for the family, including sharing visits during terminal care and bereavement. She also advises on pain and symptom control aids.

In the field of paediatric oncology we would argue that more than 'basic nursing care and love' is required. Knowledge of the likely course of these rare diseases in their terminal stages enables anticipation of symptoms and prevention or early relief, thus gaining the confidence of the parents.

It is our experience of working with the primary care team in this situation that a good working relationship is built up between hospital and general practice with trust on both sides, to the benefit of family and patient. The families of children dying of malignant disease do need specialist expertise in their management but this can be achieved as described above with the general practitioner playing a central part in the management and bereavement that follows.

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Variation in general practitioners' referral rates to consultants

Sir,

Drs Wilkin and Smith (August *Journal*, p.350) have demonstrated elegantly that there is a huge variability in referral behaviour by general practitioners and that this is not associated with any characteristics of the doctors or their patients. This applies to almost every clinical activity in general practice which has been measured and is associated with the consistency of any pattern of activity by one general practitioner over time and with the lack of association between any of the measured activities themselves.

We believe that the conclusions drawn by Wilkin and Smith are wrong. Research workers may indeed require more sophisticated information to explore variation among doctors and we welcome the initiatives of Dowie and others. Practising general practitioners are, however, not so concerned with doctor variation as they are with rationalizing their own performance. For this they need simple information about their own activities and this provides the rationale of the prescribing reports from the Prescription Pricing Authority. Such information is not generated from the routine collection of data but is based on a sample. We agree with Wilkin and Smith that the continuous collection of referral data is unnecessary, except for certain research purposes, but the implication that no referral data should be collected is highly damaging to present attempts to increase quality of care. We have argued[1] that standards in general practice evolve first from knowledge of performance, secondly from discussing performance with peers, thirdly from the identification of hypotheses capable of being tested and finally from the results of such tests. The hallmark of quality is a willingness to embark on this road but we emphasize the starting point. Once standards are defined then we may determine if and how behaviour should be modified in a 'desirable' direction. Only by providing information for general practitioners working in the field will we identify the hypotheses worthy of test. Information from studies on variation among doctors will contribute to the debate but by itself can never lead to the identification of standards.

We also disagree with the conclusions about information for health authorities. Health authorities (districts and regions) need to know what is going on. It is not their function to influence performance but to provide information and to meet patient need which can be equated with doctor demand on behalf of patients with problems.

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Reference

1. Crombie DL, Fleming DM. Quality of care in general practice. *J R Coll Gen Pract* 1983; 33: 746-747.

Table 1. Annual call and visit rates for 1985.

Management	All calls: Number (%)	All calls: Call rate per 1000 patients per year	Night calls: Number (%)	Night calls: Call rate per 1000 patients per year
Telephone advice	203 (*49*)	84	14 (*29*)	6
Home visit	208 (*51*)	86	34 (*71*)	14
Total	411 (*100*)	170	48 (*100*)	20

Telephone advice in managing out-of-hours calls

Sir,

I was interested to read the paper by Dr Marsh and colleagues (July *Journal*, p.301). I wholeheartedly agree with them that the work that a general practitioner does 'on duty at home' (being available for telephone advice to patients and visiting them in their homes) is work that receives little attention in medical literature. It is often the most stressful and irksome part of the doctor's workload.

I have kept a detailed telephone log for several years, and recently looked at the results for 1985. I work in an urban teaching practice of seven partners looking after 14 500 patients. We do not use a deputizing service; each partner is on call for the whole practice in a rota. Weekdays on call at home are from 18.30 to 08.00 hours, weekends from 11.00 hours Saturday to 08.00 hours on Monday. During 1985 I was on duty at home for a total of 990 hours, approximately one sixth of the practice on-call time. I have used this figure to calculate the annual call and visit rates of our practice in a similar way to Dr Marsh and colleagues (Table 1).

In my series no caller was refused a visit but I was able to manage 49% of callers with telephone advice. My figures are in broad agreement with those of Dr Marsh and colleagues, although at weekends more visits were made, and less managed with advice alone. The contrast with deputizing services who often visit all callers is again apparent.

One of the costs of such a system is disturbed sleep for the partners. When on duty my sleep between 23.00 and 07.00 hours was disturbed on 45% of weekday nights by calls, and on 28% of weekday nights by visits. However, 95% of weekend nights on duty were disturbed by calls and 74% by visits and this helps to explain why weekends on duty feel more stressful than weekday nights. I trust that this subject may be opened up to informed research and debate by Dr Marsh's helpful paper.

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