Like Dr Hall, I found that most of the 63 respondents (92%) kept analgesics in their home, including ibuprofen as well as aspirin and paracetamol. However, less kept paracetamol than in Dr Hall's study (78% versus 88%), and more kept aspirin (8% versus 2%). A considerable number (21%) kept both drugs, compared with none in Dr Hall's study.

Awareness of problems with aspirin was even more different in the two studies, with only 5% of my respondents being aware that aspirin should be avoided in children under 12 years of age. Only 32% knew it causes 'stomach upsets', while awareness of problems with paracetamol (22%) and ibuprofen (14%) was even poorer. In Dr Hall's study, 92% of those questioned had become aware of problems with aspirin in children as a result of the publicity campaign.

I would suggest that the effectiveness of the publicity campaign has worn off with time, even allowing for the fact that some of the people answering my questionnaire had no children, and would therefore be less likely to register 'anti-aspirin publicity'. Perhaps a further campaign should be mounted, or should it be left to general practitioners and pharmacists to ensure that they maintain the public's awareness of the dangers of aspirin and other drugs obtainable over the counter?

H. FAIRHURST

2 Clifton Park Road
Clifton, Bristol BS8 3HL

Reference

1. Hall RW. Aspirin and Reye's syndrome — do parents know? *J R Coll Gen Pract* 1987; **37**: 459-460.

The referral system and restrictive practices

Sir,

Marshall Marinker analyses the referral system with regard to the government's review of restrictive trade practices (November *Journal,* p.487). He discusses the reasons why the current referral system as operated in the NHS serves both patients and the efficiency of the service itself.

I would further develop the argument to say that consumerism, competition and choice are already available in health care provision. Consider an individual with the symptom of pain in the arm. The choices available to him are: he could put up with the pain and not seek any help; he could buy herbal or homoeopathic remedies; he could visit an osteopath or physiotherapist on a private basis; he could visit the chemist and buy tablets, ointment or a heat lamp; he could wear a copper bracelet; he might decide to obtain advice from the NHS by visiting his general practitioner; he could see a doctor privately — general practitioner or consultant.

Thus several very different choices are available. From some sources the patient can buy what he thinks might be a remedy, or he seeks advice. From the NHS, medical advice might distinguish arthritis, shingles or angina as causes of a painful arm. Only after this step can appropriate treatment be offered. The patient can seek a second opinion from another general practitioner or hospital consultant if the initial contacts are unsatisfactory. Most doctors welcome and arrange another opinion if a patient is unhappy with the outcome of consultations and cannot be mollified.

The choices of health care available to the consumer are every bit as wide as those from private commerce with regard to purchase of services and goods.

The NHS is a complex organization with its own established procedures for dealing with patients' problems which allow selection of treatments for different problems. Heterogeneity among doctors allows some variation in response to patients who themselves vary so much. The internal arrangements in private companies are often very rigid, treating all customers in the same way. But in both cases they increase efficiency and competitiveness.

I believe current NHS arrangements do not constitute restrictive practice. They do not provide any financial benefits to staff by restricting competition or output to inflate prices and earnings. Indeed the NHS is cheaper than other health care systems.

D.E.A. LUXTON

86 Gayton Road
Kings Lynn
Norfolk PE30 4ER

Sterilizing instruments

Sir,

No doubt many practitioners will be anxious about their arrangements for sterilizing instruments following the recent study published (October *Journal,* p.447) and the wide publicity which this has received in the national press. For those using pressurized steam for sterilization either in a purpose designed autoclave or in the more humble domestic pressure cooker, there is a way of being sure that

the necessary conditions for sterilization have been reached which deserves to be better known. Albert Brown Ltd, Chancery House, Abbeygate, Leicester, produce colour-change control strips which are comparatively inexpensive and simple to use. A coloured dot changes from yellow to purple in 15 minutes at 121°C or in 5.3 minutes at 134°C. The strip is placed in the pressurized chamber with the instruments to be sterilized. Our advice is that these conditions are sufficient to kill the more resistant organisms.

The adoption of this simple procedure has enabled us to feel very much more confident about the sterility of our reusable equipment without involving us in great inconvenience or expense.

P.D. TOON
J. KIRTON
A. PILKINGTON

Queensbridge Road Surgery
206 Queensbridge Road
London E8 3NB

Medical indemnity

Sir,

In your editorial (November *Journal,* p.490) you conclude that the major cause of lower subscription rates to the Medical Defence Union of Scotland is the selection and education of undergraduates in Scottish medical schools. I agree that Scottish medicine is in many ways in a healthier state than English medicine, but would argue that a greater factor in the lower rates is likely to be the exclusion of non-Scottish graduates, which includes both English and overseas graduates. Overseas graduates have more claims made against them and appear before more disciplinary hearings. This is not a reflection of the ability of individual doctors who graduated overseas, but more often a language or cultural misunderstanding.

If there were regional defence unions composed solely of graduates from, say the south west of England or Northern Ireland, then I speculate that they would have subscription rates as low as the Medical Defence Union of Scotland.

Drawing conclusions of cause and effect from comparison of two unmatched populations is invalid in the rest of the *Journal.* It is a shame that in your attempt to score a point off 'the auld enemy', you have lowered your usual high standards.

J. STC. ANDERSON

University of Glasgow Department of General Practice
Woodside Health Centre
Barr Street, Glasgow G20 7LR

Telephone consultations in general practice

Sir,

I refer to the letter by Drs Bhopal and Bhopal (December *Journal,* p.566). As the immediate past treasurer of the Medical Defence Union I am aware that the management of requests for visits by giving advice over the telephone has led, and appears likely to continue to lead, to many complaints to family practitioner committees and to negligence claims in the courts. Diagnosis without seeing the patient is potentially dangerous.

H.M. HALLE

Bramley Hollow
Ford Road, Marsh Lane
Sheffield S31 9RE

Sir,

The review by Drs Bhopal and Bhopal of telephone consultations in office hours is a welcome baseline for the study of the value of this mode of patient contact. However, it begs more questions than it answers, and the only conclusion drawn is the subjective one that the disadvantages are exceeded by the advantages. An attempt to ascertain the opinion of the patients (particularly the 2.4 per session whose consultations may have been interrupted) would have balanced the authors' conclusions better, as would some kind of objective assessment of the short- and long-term outcome. For example, how many unseen patients given advice or prescriptions (86% of the total) returned later for a full consultation for the same problem? To what extent did the saving of time for both patient and doctor set a pattern leading to an increasing percentage of patients choosing this method of obtaining a medical opinion? If the authors agree that the telephone is not the ideal setting for a consultation in most circumstances, then should we be advocating it for the banal practical reasons quoted? Why do we need to make an inferior service available as a routine?

The consultation has been exhaustively studied in recent years and we have learned to ask ourselves questions such as: Why did the patient consult? What were his expectations? Was he given time to air his problems? Was he satisfied with the outcome? We should be prepared to subject telephone consultations to the same rigorous examination as the face-to-face contact.

If the patient is encouraged to regard a telephone call as an easy option, then