minutes and 20 minutes. Following a telephone consultation and the issuing of a prescription where appropriate the number of patients no longer wishing to attend the surgery were four, two, two and none on each of the four evenings.

The normal booking interval is 10 minutes per patient. Thus there was no net saving of time in conducting telephone consultations before surgery consultations. The study was therefore not pursued further.

The approach seemed to be acceptable to the patients and was easy to perform. Doctor initiated telephone consultations are an interesting area for research and saving time is only one aspect. Doctor initiated telephoning allows more control over patient selection and workload and as for patient initiated telephone consultations the need for a surgery attendance or home visit may be obviated.

KARL STAINER

23 Ashgrove Road
Redland
Bristol BS6 6NA

Admission times for patients with myocardial infarction

Sir,

In their paper on mode of referral and admission time to coronary care units for patients with suspected myocardial infarction, (April *Journal,* p.145) Ahmad and colleagues, make some interesting conclusions which I fear are correct but cannot be supported by their study.

I appreciate the value of thrombolytic therapy and see that initiating therapy quickly is important. Therefore, increasingly, when contacted by a patient with a classical history of myocardial infarction I instruct the patient to telephone for an ambulance. I may attend, hoping to meet the ambulance, but usually find the paramedical team more than capable of dealing with the situation. To class these patients as 'self referrals' ignores an important part of primary care. There is a need to reduce unnecessary referrals and the more we encourage a fast track approach then the longer the delay for the 'general practitioner referred' patients. The patients I attend are those who have atypical chest pain or an imprecise history. Obviously, by attending the patient a delay is caused in their hospital admission, but sending them all via emergency ambulance is impractical.

The two groups of patients in the study may not have come from the same population and therefore may not have been entirely comparable. For example, there were significantly more Asian patients in the self referral group — were similar numbers of patients in both groups registered with a general practitioner?

Classifying severity on arrival at the coronary care unit in terms of chest pain is misleading: the general practitioner referred patients may have received adequate analgesia by injection.

Finally, the study did not include those patients who had died before reaching the coronary care unit, and those patients who referred themselves, did not have cardiac chest pain and were not admitted to the coronary care unit. Survival is the most important outcome, not delay in admission, therefore it would be interesting to know whether mode of referral actually affects mortality. Further research in this area, involving general practitioners, would be useful.

M J B WILKINSON

62 College Road
Sutton Coldfield
West Midlands B73 5DL

Differential diagnosis of otitis media and externa

Sir,

McCombe and Rogers (letters, April *Journal,* p.170) present results of a postal enquiry into the differential diagnosis of otitis media and externa referring especially to confusion in the diagnosis of otitis externa. No mention was made of the age of patients or the diagnosis in children.

In 1976 I reported in some detail a survey of 300 consecutive new cases of earache of aural origin in general practice, and predominantly in children with otitis externa.[1] I discussed the differential diagnosis in children in detail and asserted that otitis media is not as common as is believed. I also pointed out that hospital doctors do not see otitis externa in children because of its fleeting nature. Hospital doctors teach general practitioners how to examine ears, without mentioning otitis externa specifically as a common pathological entity in children.

JOHN PRICE

Little Orchard
Church Lane
Sidlesham
Chichester PO20 7RH

Reference

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GP working style and patient health status

Sir,

The paper by Huygen and his team (April *Journal,* p.141) on the relationship between the working styles of general practitioners and the health status of their patients addresses perhaps the most important concern for general practice. Unfortunately I am not yet convinced that the presented data sufficiently support such an important and welcome conclusion, that imaginative practice gives better outcomes. An effect from patient selection is not adequately excluded. If 'good' doctors get 'good' patients, then 'bad' doctors get 'bad' patients; as Robin Pinsent memorably, though in my opinion wrongly, once remarked to me, 'doctors get the patients they deserve.'

If the authors could give more data relating directly or indirectly to the social class of the women in the three general practitioner groups showing no systematic differences this could reinforce their conclusion. However, even within small social categories, selection, and deselection of doctors can have a powerful effect. My own experience with a virtually closed, almost entirely manual working class population, was that over many years a small number of patients (usually about seven families out of about 500 families in the village) were hostile to policies of anticipatory care, and preferred prescription, certification, and referral more or less on demand, which our practice would not provide. This certainly led to systematic bias and, for this reason, when I tried to compare mortality outcome with adjacent practices, I compared the villages, not the practices.[1] Though the group of patients registered with other practices was always small, its group behaviour would probably have been sufficiently deviant to affect results profoundly had we undertaken a study similar to that of Huygen and colleagues.

The conclusion by Huygen and his team may be true (I believe it probably is) but the two explanations (a real effect and an effect of social selection) are not mutually exclusive. I suspect that social selection is quantitatively more important.

JULIAN TUDOR HART

Gelli Deg
Penmaen
Swansea SA3 2HH

Reference

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