OUT-OF-HOURS WORK

Sir,

I found your editorial and Dr Lockstone's paper (January *Journal*) interesting. I have no doubt that your " extended cover system " gives the patients better medical care and is best suited to a group practice, certainly a practice working in a town away from conurbations. This can be clearly deduced from comparing Dr Lockstone's paper with Dr Gabriel's (p. 74) in the same issue, on an emergency call system.

In a study of night calls I made in my group practice of four doctors from 1 January 1960 to the 31 December 1965 (excluding midwifery) our call rate was 6·6 per 1,000 patients (Pritchard, 1966) as compared with Dr Lockstone's rate of 10·7 in 1974. Our present night call rate is lower still and Dr Lockstone's paper further confirms an interesting fact, which has not been fully explained, that the further north a practice is in the United Kingdom the higher the night call rate, according to the papers so far published.

I consider Dr Lockstone's paper completely demolishes the curious statement he quotes from the *BMA News* that " night work merely satisfies the doctors delusions of grandeur ". . . Anyone who wrote that has not been pulled from his warm bed to drive through a cold and snowing night to see a patient. The statement goes on to say that night calls . . ." could be withdrawn permanently without serious loss " . . . Dr Lockstone proves conclusively that this is totally incorrect. His total of " irresponsible " calls totalled 11 (seven per cent). Ours I labelled " frivolous " and totalled 13 (2·5 per cent) of 325 calls in six years. In other words the vast majority were necessary and many were literally life saving.

J. N. A. PRITCHARD

Alexander House,
2 Salisbury Road,
Farnborough, Hants.

REFERENCES

Journal of the Royal College of General Practitioners (1976). Editorial, *Out-of-hours work*, **26**, 3–4.

Lockstone, D. R. (1976). *Journal of the Royal College of General Practitioners*, **26**, 68–71.

Pritchard, J. N. A. (1966). *British Medical Journal*, **2**, 614.

COLOUR TAGS FOR ABUSED CHILDREN

Sir,

In view of the widespread interest in non-accidental injury and neglect to children, and the odium which has occurred with slip-ups, I feel it is essential to have a colour tag on the medical records of families at risk. We have started to use the pink tag with a little hammer drawn on it, but I feel that something should be agreed on a national basis.

Your readers' comments would be appreciated.

G. A. WILLCOCK

9a Coggeshall Road,
Braintree, Essex.

NOMINATIONS FOR FELLOWSHIP

Sir,

May I enlist the services of the *Journal* to ask those of our colleagues who are nominating members for the Fellowship to ensure that their nomination forms are completed in typescript, on grounds both of legibility and of economy?

At present, many nomination forms are received completely in manuscript; valuable time and effort are then spent by our secretariat at Princes Gate in retyping these forms so that they may be made legible for the members of the Committee on Fellowship. As you will know, each nomination requires three sponsors, each of whom completes a form; with an average of some 50 nominations to digest each time, the members of the Committee have to study some 150 forms in detail.

It would therefore be most helpful if all forms were received already typed, when they can be readily photocopied. To avoid wasting time and effort at Princes Gate, our secretariat have now been instructed to return forms received in manuscript to their originators, with a request that they be typed. It is well realised that this may impose a disappointing delay in some nominations, but the necessity for economy has now become so acute that your Committee on Fellowship feels that this procedure is fully justified.

One final point, may I re-iterate that sponsors should be Fellows of the College or members of more than five years' standing?

DONALD IRVINE
Honorary Secretary of Council

14 Princes Gate,
Hyde Park,
London, SW7 1PU.

THE DISTRIBUTION OF EPISODES OF ILLNESS

Sir,

Dr Kilpatrick's empirical finding that the frequency of episodes of illness per patient per year has a geometric distribution (September *Journal*), though interesting, is not as useful as his subtitle ' a research tool in general practice? ' would seem to suggest.

When comparing real data with a theoretical statistical distribution, it is customary to carry out a statistical significance test (often referred to as a ' goodness-of-fit ' test) to see how well the data fit the distribution. On this occasion such a test identifies a discrepancy between the data of the National Morbidity Survey and the geometric distribution advocated by Dr Kilpatrick ($\chi^2_8 = 536$). In particular the number of patients who suffered ten or more episodes was some 18 per cent less than predicted (1,577 compared with 1,908).

However, it would be unfair to describe the geometric distribution as a mediocre fit for these data without first proposing a distribution which would provide a better model for the data. Such a distribution is provided by the negative binomial distribution, which has been shown by Ashford and