Sir,
I have been interested to read the recent correspondence in our *Journal* regarding membership of the College.

I am a founder Associate of the College and have been in active practice for over 30 years. I remember many years ago receiving a form inviting me to become a Member at an increased annual subscription. Because of being away on holiday at the time, I think, the form was not returned by the required date and I thought nothing else of it until, soon after, I noted that some of my colleagues were adding MRCGP to their signatures with a flourish, having done no more than return the form on time, and that I now had to pass an examination if I desired to do the same.

Is this food for thought?

C. R. LYNN

68 Harley Street
London W1N 1AE

Bromazepam, a new anxiolytic

Sir,
Having recently joined the College, I was disappointed to see that the second College *Journal* I received (September *Journal,* p.509), contained a promotional article, disguised as a scientific paper.

The article in question is 'Bromazepam, a new anxiolytic: a comparative study with diazepam in general practice'. I note that the paper was co-written by someone employed by the company that makes bromazepam, thus casting doubt onto the objectivity of the study.

The summary states that bromazepam is as effective as diazepam as an anxiolytic. It then goes on to say 'a global rating scale showed that in the physicians' opinion, the lower dose of bromazepam was preferred' — a highly subjective statement, and, if you read the text of the paper, one which is based on a statistically insignificant result. The summary, therefore, implies that bromazepam is a superior drug to diazepam, which is not born out by this paper.

I particularly object to this article because bromazepam is an unnecessary drug, as there are already too many benzodiazepines on the market, and most doctors are reducing their prescription of the drugs, as we have become aware of the problems of addiction to benzodiazepines.

JAMES LENEY

20 Marlborough Road
London N19 4NB

Social class and health status

Sir,
In their letter (September *Journal,* p.492), McPherson, Coulter and McPherson quite rightly point out that there is little to justify the assumption that recurrent episodes of illness are all initiated by the general practitioner rather than by the patient. Without this assumption, Dr Crombie's assertion that general practitioners compensate for under-use of services by social classes 3, 4 and 5 is unsupported.

But there are some additional problems with the 1971 analysis that has made interpretation difficult. The first point is that in comparing different social classes account must be taken of the reasons why they consult and the different diagnoses for which they consult. A consultation for a cold is not comparable to a consultation for lung cancer or immunization against whooping cough. The Registrar General's *Decennial supplement on occupational mortality*[1] provides a useful set of individual diagnoses and sets of diagnoses for serious conditions, such as chronic bronchitis; asthma and emphysema; ischaemic heart disease. It would be helpful if such a presentation could be included in the 1981 figures for persons consulting and episodes and consultation by social class.

Secondly, there is a difficulty in interpreting social class gradients in this study. Like Fox and Goldblatt's longitudinal study,[2] which deals with the mortality of a 1 per cent sample of the 1971 Census, people are classified into social classes 1–5, 6 (Inadequately described) and 7 (Unoccupied at the time of the Census). Fox[2] has described how half of the 'inadequately described' class 6 were temporarily out of work owing to sickness, and most of the 'unoccupied men' class 7 were permanently sick. In other words, men who are sick tend to be classified as social class 6 or 7 rather than 1–5. Furthermore, men in social class 5 are six times more likely to be allocated to the 6 and 7 groupings. The same selection effect takes place in the general practitioner study and the consultation rates for social classes 3, 4 and 5 are going to be considerably reduced because of it. Hence great care must be taken in interpreting gradients across social classes, as the slope is likely to underestimate consultations in social classes 3, 4 and 5.

These provisos do not invalidate the use of social class in analysing data from the National Morbidity Survey, but they should engender caution in interpreting results, particularly when they run counter to most published material.

J. ROBSON

70 Cadogan Terrace
London E9

References

1. Office of Population Censuses and Surveys. *Occupational mortality 1970–72. Registrar general's decennial supplement.* Series DS1. London: HMSO, 1978.
2. Fox J, Goldblatt PO. *Longitudinal study. Sociodemographic mortality differentials 1971–75.* London: HMSO, 1982.

Night calls: an emotional issue

Sir,
I was so intrigued by Dr Stevenson's angry response (September *Journal,* p.496) to your July editorial on night calls that I went back to read the original. I must say that I agree with Dr Stevenson that it is a perplexing collec-

ion of unfounded assumptions. Our study on out-of-hours calls[1] set out to examine the apparent difference in demand and response rate for such calls in two similar practices. We demonstrated a marked difference in demand between the two groups and a marked difference in the way that doctors responded to requests for out-of-hours calls. We concluded 'in those cases where not to visit would be widely agreed to be negligent or, at the very least, to be legally hazardous the decision making process is clear. In less clear cut cases however our results show that the doctor's decision is not necessarily based on medical factors or experience but rather on the doctor's assessment of non-medical needs that might be met by his visiting, and on the expectation of the patient.'

The anonymous editorial writer evidently considers himself or herself to be on the side of the angels, the doctors who would respond with selfless care and compassion to each imagined psychological need of the patient at all times of the day and night. But is it really compassionate to destroy the patient's autonomy? Or is it more appropriate, as Dr KB Thomas[2] in his response to our original article suggested, to instigate changes in the attitude of doctors: 'changes that involve sharing realities with the patient and attempting to increase his confidence and independence.'?

TERRY CUBITT

The Health Centre
Alton
Hampshire GU34 2QX

References

1. Cubitt T, Tobias G. Out of hours calls in general practice: does the doctor's attitude alter patients' demands? *Br Med J* 1983; **287**: 28-30.
2. Thomas KB. Out of hours calls in general practice. *Br Med J* 1983; **287**: 362.

Sir,
The thinking behind Professor Morrell's letter (October *Journal,* p.562) is difficult to understand. Is his argument that daytime doctors are more afraid than night time doctors or that they are physically weaker, or that night doctors (deputizing services) are in some way better armed and less likely to be assaulted than their daytime equivalent.

Whatever the reason, night calls will still have to be made to patients who are ill as I am sure that Professor Morrell cannot be contemplating the total removal of medical care after darkness in inner city areas. Surely he is confusing two issues, the first that daytime doctors for their own reasons, may not wish to do out-of-hours calls at night and the second that there may be danger to doctors walking the streets and going up tower blocks at night in certain inner city areas. These problems may well have to be solved either by providing a suitable 'minder' or alternatively by arming the doctors more heavily.

I submit these issues as separate ones and both should be debated on their own merits and not confused.

R. M. RIDSDILL SMITH

Thornhills
732 London Road
Larkfield
Kent ME20 6BG

Home confinement

Sir,
Dr F Dobbs (Letter, November *Journal)* has two strong criticisms of my article, (August *Journal,* p.425). Unfortunately I cannot follow his calculations, therefore I will give my own calculations.

The study (see reference 7 in my paper) was meant to investigate if there was a difference in the outcome of expected normal confinement between women who opted for a home confinement and those who opted to deliver in hospital. Dr Dobbs states that failure of progress in labour is a condition virtually confined to primigravidae and, indeed, the proportion of I-parae in both groups had to be taken into consideration. This is as follows

On page 427 I state that 18.4 per cent of I-parae had chosen home confinement, that is, 18.4 per cent out of 830 = 152 (Table 1). There remained 678 hospital-booked patients, includng 50 with a 'primary medical indication'; which means there were 628 I-parae who expected to have a normal delivery in hospital. From the first mentioned 152 I-parae, 5 per cent, that is, eight women, were referred to hospital during pregnancy (Figure 1), leaving 144 women. From those who opted for delivery in hospital 14 per cent were referred, that is 88 women (Figure 1), leaving 540 I-parae who could be expected to have a normal confinement. From these I-parae (Table 6) 17 out of 144 women (11.9 per cent) and 111 out of 540 women (20.6 per cent) were referred because of failure to progress in the first stage of labour. There was therefore a clear difference in favour of those who had opted for home confinement.

As to the diagnosis in the two groups — I agree that in any study comparing incidences the same criteria have to be established.

In this study the deliveries in both groups were performed by at least eight different midwives, 20 different general practitioners and 10 different obstetricians. I therefore neglected the personal influence of the medical assistance on the criteria used for diagnosis in this study.

S. M. I. DAMSTRA-WIJMENGA

Van Ketwich Verschuurlaan 5
9721 SB Groningen
The Netherlands