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.'?

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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.

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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.

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