

hospitals' excess mortality was shown (Table 1, p.391). To dispose further of Dr Watney's thought about premature births, it is virtually certain that the mortality rate was much higher in hospital at every specific birthweight, low and high.¹ Supporting evidence for this probability was found in New Zealand in 1978-81, where mortality was significantly higher at all weights over 1500 g in the specialist hospitals.²

The other criticisms can be more briefly answered. I apologize that the reference index was omitted from the paragraph dealing with the correlation of trends in hospitalization and mortality rates (p.393). The detailed data can be found in references 11 and 8 (p.394). Dr Madeley and Professor Symonds can be reassured that the technique of trend analysis is valid³ and leads to valid inferences which the data as quoted by them do not. The Dutch study referred to was a comparison of outcome between matched groups.⁴ It is irrelevant that the proportion of births in hospital in Holland is increasing, a trend which, as in Britain, is not justified by their results. Sweden's low perinatal mortality reflects the high standard of health of the Swedish population, confirmed by other indicators. The Nottingham finding of mothers' equal satisfaction with hospital and home care is not confirmed by other studies^{5,6} and may not be independent of the setting in which the research was conducted. The example of standardization in Appendix 1 (p.393) illustrates an orthodox statistical technique appropriately applied; the 'assumptions' required of Dr Watney are no more than the rules of multiplication and division.

The fact is that the criticisms made of this article, of its data, its analysis or its reasoning, cannot be sustained. Its inferences, therefore, are not refuted. If health authorities continue to disregard them and fail to modify their policy accordingly, it will be clear that the maternity service is organized in the interest of the most influential of those who provide it and not of those who have to use it.

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Out-of-hours calls revisited

Sir,

The general conclusions from the study by R.D. Walker (September *Journal*, pp.427-428) were that fewer than expected night calls were made to children by general practitioners. Of the calls made, the majority were to children who were suffering from infections (61%) and the majority were under five years of age (68.7%). Fewer than 5% of children were admitted to hospital after the general practitioner referral.

As part of a study evaluating the work of a night duty health visitor service in North London¹ analysis was made of the reasons for contacting the service. Sixty-five per cent of parents contacted the health visitor because they were not sure if the problem was serious enough to contact the general practitioner. Several said their general practitioner was not available and others said that they did not want a deputizing service. The main problems were crying (19%), vomiting (15%) and diarrhoea (14%). If the health visitor service had not been available 32% would have used a deputizing service, 25.5% would have adopted a 'wait and see' position, 12% would have used casualty, 17.5% would have contacted relatives and friends, 10% would have used the midwifery service, and others would have contacted the police, neighbours or a chemist. As can be seen, several would have used casualty. Indeed a survey of casualty attendances by children under five years of age at a north-east London hospital during the same three-month study period of the night duty health visitor service² identified that 143 children (9% of the total number of attendances) were seen out of usual working hours with minor disorders, the same type of minor infections that were seen by both the night-time health visitor and the general practitioners in Dr Walker's study.

A study by Jackson³ looking at attendances of children at an east London paediatric hospital found that parents perceived the hospital as offering faster attention and doctors who were better trained and that the unavailability of general practitioners led to the use of casualty by non-urgent cases. Other studies⁴⁻⁸ have supported the view that accident and emergency departments are

inappropriately used and deal with paediatric problems which are well within the range of primary care.

In a study by Tulloch⁹ of calls to a general practice from 18.00 hours onwards on weekdays, he suggested that a nurse could have handled 46% of the calls alone. Cartwright's study of doctors and patients¹⁰ showed that general practitioners often found their work 'trivial' and 'tedious'. In her study 'trivial' work included such problems as colds, constipation, coughs, teething and minor sickness. While Walker's study indicated that a lower than expected number of parents contacted the general practitioner at night for their child's problems, the reason may not be that the problems do not exist in greater number, but that the parents may choose alternative sources of help or may delay seeking help because of not wishing to bother the doctor. Alternative sources of help may include the inappropriate use of the casualty department.

These studies indicate the need for general practitioners and their trainees to explore when their patients may be using alternative and possibly inappropriate forms of care, and if they are doing this — why?

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