

Sir,  
The paper by Marsh and colleagues (July *Journal*, p.301) alarmed me on several counts. It seems evident that the authors are in favour of telephone management but by its very nature the basic medical precepts of history, examination, investigation, diagnosis, prognosis and treatment are violated since management must be decided from history alone. To reassure patients, prescribe and even admit to hospital on this basis seems to be inviting disaster.

The authors state that only 30% of callers were known to the doctor receiving the call. Calls are often made at times of physical, social or psychological crisis and non-physical factors affect the decision to visit. In the absence of such knowledge, to offer advice alone may be totally inappropriate.

The authors also state that 'the doctor knows from the address whether the patient lives in a deprived area, when the history may be inaccurate and when social circumstances may worsen the illness'. To use such a patronizing assumption to help to decide whether to visit or not is outrageous.

It is also stated that there was no evident detriment to the patients' health but this was measured retrospectively and in physical terms only. Fifty five per cent of patients given advice only and 65% of patients asked to attend the surgery, consulted again within a week. These patients, therefore, did not feel healthy.

The failure of the doctor to visit at a time of crisis could easily damage the doctor-patient relationship and prescribing without examination of the patient may also lead to unnecessary or inappropriate medication.

I would agree that some calls can be easily dealt with by telephone advice alone, usually when specifically asked for by the patient. However, with no benefit to the patient, possible damage to the doctor-patient relationship and inappropriate and unnecessary prescribing, one must question one's motivation in reducing a commitment to patients in this way and ask if this is responsible medicine.

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Sir,  
May I take this opportunity to congratulate Dr Marsh and colleagues on their excellent study of telephone advice in managing out-of-hours calls (July *Jour-*

*nal*, p.301). Dr Marsh states that his out-of-hours visit rate of 47.5 per 1000 patients per year is with one exception<sup>1</sup> the lowest reported so far. However, this is only the number of visits made by the doctor to the patient's home. He must add to this the face-to-face consultations that occurred at his surgery during the out of hours periods. This would then give a total visit rate of 53.8 per 1000 patients per year which is not dissimilar from Riddell's 58.6 reported in his inner urban area of Glasgow.<sup>2</sup>

The study which Dr Marsh refers to as showing the lowest out-of-hours visit rate is that by Crowe and colleagues.<sup>1</sup> In their practice of 9500 patients in semi-rural Leicestershire they performed 416 home visits in out-of-hours periods — 43.8 visits per 1000 patients per year. But when all face-to-face consultations are included this gives an overall visit rate of 62.1 per 1000 patients per year, making Dr Marsh's 53.8 the lowest. I am surprised that Dr Marsh did not refer to Webster and colleague's study of night calls, in a practice of 7997 patients in 1960-63.<sup>3</sup> They found a night call rate of 10.7 per 1000 patients per year for the period 23.00 to 08.00 hours. Lockstone<sup>4</sup> defined a night call as one between 23.00 and 07.00 hours. Therefore if the calls between 07.00 and 07.59 hours in Webster's study and the calls given telephone advice only are subtracted this gives the night visit rate as 9.5 per 1000 patients per year, which is similar to Dr Marsh's 9.8.

Webster's practice gave telephone advice to 4.5% of night calls compared to Dr Marsh's 58.2%. Perhaps the unusual arrangement in Dr Marsh's practice where each doctor is on call every weekday night for his own patients is responsible for the higher call rate. It may be an incentive for patients to telephone for advice. Some studies<sup>5-9</sup> refer to out-of-hours calls as actual visits by the doctor to see the patient, while others<sup>1,10,11</sup> refer to them as telephone calls coming from the patient. May I suggest that all out-of-hours telephone calls to the doctor be used to calculate the 'telephone call rate' whether or not a visit is made and that the number of face-to-face consultations be used to calculate the 'visit rate'. Calls and visits between 23.00 and 07.00 hours would be used to calculate the respective night rates. Such standardization would help to clear up much confusion, especially when attempting to compare studies.

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Sir,

Dr Marsh and colleagues have written an interesting paper (July *Journal*, p.301), but I cannot agree completely with their ideas.

I have been out of practice for some years now, and must admit to being a whit old-fashioned; but I do think there is something to be said for seeing the patient. An obvious jaundice, the caller might mention, but a trace of icterus in the eyes might go unnoticed; a parent or relative might easily miss a very slight tremor. Nor is it possible, over the telephone, to make a judgement about possible non-accidental injury, or simply to tell if a child seems frightened.

'Clinical medicine' means practising medicine by the bedside. And it always will.

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#### A team approach to terminal care

Sir,

Dr Aldridge has published a challenging article (August *Journal*, p.364) on the implications for general practitioners of a team approach to terminal care. Challenging is perhaps a kinder adjective than patronizing.

In his article he refers to the developing skills of counsellors. He seems, however, to discount the skills which general practice has developed over many years of experience in dealing with chronically ill or terminally ill patients,

and the efforts of vocational training schemes to increase the skills of young doctors in this area.

Dr Aldridge cites much anecdotal evidence in support of his views. However, most caring doctors will use any agency to supplement their own care in appropriate circumstances and Dr Aldridge should recognize that some doctors and some patients find his approach intrusive and unhelpful in a doctor-patient relationship which has often been nurtured over many years.

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### Serum theophylline concentrations in general practice patients

Sir,  
Dr Howard concludes in his paper (March *Journal*, p.105) that less than 25% of general practice patients were achieving a theophylline concentration in the therapeutic range. As Napp Laboratories are the manufacturers of Phyllocontin Continus tablets which were taken by the majority of patients in Dr Howard's study I would like to make the following comments.

Of the 34 patients taking Phyllocontin Continus, 26 were taking one tablet (225 mg) twice daily, one patient took one at night and one patient took one tablet three times a day. We have for some years now tried to persuade general practitioners to prescribe two tablets twice daily as a maintenance dose. However, general practitioners might not be at fault. Dr Howard did not quote an original source in his justification but Mitenko and Ogilvie<sup>1</sup> showed that the dose-response relationship was a log relationship. Thus bronchodilation can be seen at 27.5  $\mu\text{M}$  or even lower.<sup>1</sup> However, even in a patient with little or no reversibility, theophylline can improve lung function although it is not demonstrable by the traditional parameters of peak flow and forced expired volume.

We have recently sponsored a trial of controlled-release theophylline in irreversible airways obstruction but in addition to measuring peak expiratory flow rate and the forced expired volume in one second which measures large airways, we also measured trapped gas volume, slow vital capacity as well as six-minute walking distance. A validated computer predictor programme was used to optimize dosage in each patient — the programme

establishes pharmacokinetic variables from a single blood sample, and optimum theophylline levels by means of Bayesian analysis. We looked at all outcome measures at serum theophylline levels of 0, 6.3 ( $\pm 0.37$ ), 12.1 ( $\pm 0.33$ ) and 18.3 ( $\pm 0.52$ )  $\mu\text{g l}^{-1}$  (or 0, 34.6, 66.6, 100.6  $\mu\text{M}$ ).

A dose-response relationship was observed for trapped gas volume, slow vital capacity and six-minute walking distance even at the lowest theophylline dose. It is especially noticeable that the trapped gas volume fell by 22.8%, 42.9% and 63.6% respectively for the three doses. The forced expired volume and peak flow only showed statistically significant differences at the highest level of theophylline.

This demonstrates that theophylline has an effect on smaller airways whose calibre is not measured by peak flow or forced expired volume. The fact that this effect was correlated to a dose-response effect in increased walking distance is remarkable evidence of the value of smaller airways dilation in chronic bronchitics. Thus, the therapeutic window which is readily accepted is probably too narrow in terms of effects on larger airways and is certainly so in terms of smaller airways.

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### Antibiotics in acute otitis media

Sir,

I would like to comment on recent studies of the use of antibiotics in children with acute otitis media. In the interests of epidemiological purity, the patients' symptoms seem to have been overlooked. Several studies<sup>1-4</sup> support the notion that antibiotics may not influence the short or long term sequelae of otitis media and that the condition is self-limiting and relatively benign. Do antibiotics help relieve the pain and discomfort acutely? Diamant,<sup>1</sup> in his study of the effect of withholding antibiotics at the first encounter with patients with otitis media, only mentions pain briefly. Van Buchem<sup>2</sup> tried to estimate pain levels in children with otitis media but the use of a mixture of analgesics, sedatives and nose drops spoilt the results. In a later paper<sup>3</sup> he

describes how an 'estimated' 4860 children with otitis media were treated with analgesics and nose drops for three to four days before being divided into severe and less severe groups. Only 10% were deemed severe on the basis of continuing symptoms such as pain. No mention was made of the discomfort experienced in the first three days nor were the side effects of the nose drops mentioned. The impression was given that severe pain resolved more quickly with antibiotics than with myringotomy alone but the numbers involved were small.

Hopefully the current research mentioned by Bain<sup>5</sup> will help to answer the remaining questions about otitis media. Until then many of us will continue to prescribe antibiotics at the first encounter with a child who has otitis media in the belief that pain relief will be faster and perforation may be avoided.

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### Ethics and the pharmaceutical industry

Sir,

Dr Wall's paper (June *Journal*, p.267) has turned the debate on the relationship between doctors and drug firms back to general practitioners once again. I believe an awkward relationship has been helped only a little by the guidelines that have been suggested.

Drug companies exist to make the maximum profit for their shareholders and it is a secondary matter that this profit is made out of products designed to lessen human suffering. All advertising and promotion influence those who receive it — £160 million is being spent on promoting drugs to general practitioners<sup>1</sup> and to consider ourselves immune from its influence is naive.

We are the servants of the public and we are spending their money on the drugs we prescribe. It is essential that our judgement as to what is in the best interests of a patient is unimpaired by promotional