to make the matter more complicated, patients do not realize that the general practitioner can help to solve these physical difficulties. However, the general practitioner is in an ideal position to analyse the situation and to advise the patient where to go for advice.

One such place is a disabled living centre. There are 15 offering a fully comprehensive service and six a limited service around the country and these centres provide a number of services including information on all aspects of disability for carers, a teaching base where seminars and exhibitions can regularly be held, and a centre where disabled people may go to try out equipment.

In December 1981 a disabled living centre opened in Leeds in the grounds of a geriatric hospital. It houses over 3000 of the 7000 pieces of equipment available to help disabled people. The centre and its functions have regularly been advertised on regional television and radio and in the local newspapers. Leaflets and posters can be seen in the city's libraries and in many hospital outpatient departments. All general practitioners in Leeds were sent a poster to be displayed in the waiting area and were invited to open days at the centre with the proviso that if they were unable to attend they would be made welcome at a time to suit. Only 10 of the 380 general practitioners in Leeds had visited the centre four years after it opened.

In order to discover why their response was so poor a questionnaire was sent to all 380 general practitioners in the Leeds Metropolitan district. The questionnaire sought a brief description of the practice and whether the staff were aware of the centre and its services. It asked for subjects of interest for teaching purposes and further questions sought to ascertain whether the doctor was aware of where items of equipment commonly used by disabled people may be obtained. No reminder was sent.

Fewer than 50% of the 138 respondents had heard of the centre prior to receiving the questionnaire and 21% had the poster on display. Although all district nurses and health visitors had been invited to attend a study day at the centre or to be shown around, only 30% of those known to the respondents had done so. A varying proportion of respondents knew how to obtain the most commonly used pieces of equipment — disabled driver's badge 71%, commode 11%, bath aids 52%, and wheelchair 48%. It was interesting to note that only 25% of the respondents felt that patients were disabled if they could not get out of their home.

Inability to control one's daily life is a frustrating and depressing experience and carers frequently feel tied to the home because the disabled person is not able to make a drink, go to the toilet, reach the telephone, or make a small snack for him/herself. A visit to a disabled living centre and a call to a community occupational therapist should change this situation. With the correct equipment and efficient tuition independence in simple tasks can create a more fulfilled and happier patient.

As an occupational therapist I would like to see therapists working in health centres, attending practice meetings, identifying the functional difficulties of patients and helping to solve their problems, but, given the shortage of occupational therapists this is just a pipe dream. Nevertheless, one solution is for general practitioners to be aware of potential problems, and to direct patients to a disabled living centre where advice and help can be sought. All visitors are seen by a qualified member of staff who will spend as much time as necessary assessing and guiding the patient to the correct pieces of equipment. The centres are usually open from 09.30 to 16.30 hours Monday to Friday.

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Telephone management of out-of-hours calls

Sir,

Dr Gadsby's figures for out-of-hours workload (Letters, October *Journal*, p.462) demonstrate why he finds weekends on duty more stressful than weekdays, with a higher disturbance rate, telephone call rate and night visiting rate at weekends. I have recorded all out-of-hours work for four years covering a population of approximately 13 000 and 223 nights on call (159 week nights) or 15% of the practice work. While my figures for weekday work are in broad agreement with those of Dr Gadsby they differ at weekends. Although I am twice as likely to visit a patient between 23.00 and 07.00 hours at weekends (33% of weekend nights versus 17% of weekday nights), the rate of calls managed by telephone is less (28% versus 40%) and the overall disturbance rate not very different (56% versus 61%). Between these hours telephone calls result in a visit on 54% of occasions at weekends and only 30% of occasions during the week.

My night visiting rate per 1000 patients per year is the same (6.0) as when last studied[1] five years ago. The rate for telephone advice calls for 23.00–07.00 hours is 10.2 per 1000 patients per year, giving a total disturbance rate of 16.2 per 1000 patients per year. The respective figures for all out-of-hours work are 35.9 (visiting rate), 102.4 (calls managed by telephone) and 138.4 disturbances per 1000 patients per year, thus, as before[1] confirming a lower visiting rate than any other study, contrary to Dr Coleman's letter (October *Journal*, p.463). However, the total disturbance rate is very similar to that found by Dr Marsh (129.9) (July *Journal*, p.301).

Of 1099 out-of-hours disturbances over four years, 813 (74%) were managed on the telephone and 286 (26%) required visits, compared with 58.6% and 36.6% in Dr Marsh's study. Between 23.00 and 07.00 hours there were 129 disturbances of which 81 (63%) were managed on the telephone and 48 (37%) by visits, compared with 58.2% and 41.8% in Dr Marsh's study.

These studies have shown repeatedly that a good proportion (49–74%) of on-call work can be managed successfully on the telephone. Dr Marsh is to be congratulated on a well argued case against those who do not credit the patient with any initiative or intelligence and believe every call needs a visit. It is up to them to produce more than anecdotal evidence that patients suffer as a result of management by telephone.

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Sir,

We were interested to read the paper by Drs Marsh, Horne and Channing on telephone advice in managing out-of-hours calls (July *Journal*, p.301). The figure of 59% of calls managed by telephone advice approximates to the 70%

established in our series of studies in the USA.[1-3] The authors' comments support our view that patients or their families call when they can no longer tolerate the symptoms and anxiety and they are often seeking clarification and reassurance rather than specific treatment for their illness.

In our interview survey of an 8% sample of 12 449 out-of-hours callers there were interesting differences in the length of time that patients waited before calling the doctor — 66% called within several hours of the onset of symptoms, while amost 30% waited for at least a day.[3] Furthermore, the doctors tended to perceive the reason for the call as a physical problem significantly more often than the callers, many of whom indicated that worry played an important part in their request for help.

Doctors in the USA rarely make home visits out-of-hours, or even during the day, but other reasons for 'telephone medicine' exist. Doctors can telephone prescriptions to the chemist for patients to collect as there is no requirement for the patient to present a written prescription. In addition, many patients live 30 miles or more from their doctors and careful telephone management of medical problems is a practical approach for these patients.

Telephone medicine is now an integral part of the training of most family doctors and paediatricians in the USA and a number of educational methods (including simulations and trigger audiotapes) have been developed.[4,5]

Finally, we found it disappointing that Drs Marsh, Horne and Channing omitted to quote the recent literature on the subject of telephone medicine from family practice in the USA.[6-9]

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The health needs of homeless families

Sir,
Dr Golding's editorial (October *Journal,* p.433) illustrates the difficulty of trying to provide care for homeless families. I would take exception to one point in his last paragraph when he describes the needs of such families. What these families need more than education in life skills, child care or family planning is a home in which to live. Until they have a home, much good work and money will be misdirected and wasted. It is our responsibility both as doctors and as citizens to do all in our power to try and end the dreadful state of affairs where over 100 000 families in this country are homeless.

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Antibiotics in acute otitis media

Sir,
In his letter (October *Journal,* p.464) Dr Brogan expresses the understandable concern that withholding antibiotics in the treatment of acute otitis media may result in the patient experiencing prolonged pain. In my study into this condition,[1] I found that on discussion the majority of parents were willing to delay treatment for 48 hours. Rapid settling of the symptoms with analgesia alone was observed within this period, and several parents commented that in a previous episode the resolution of symptoms following one or two doses of an antibiotic had been so rapid that they had wondered whether the treatment was really necessary. The pattern of resolution was in accordance with other studies.[2] Antibiotics are costly and may be the cause of greater morbidity than the conditions for which they are used. We will all welcome the results of the current research mentioned.[3]

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General practitioner referrals

Sir,
Hospital outpatient waiting lists are at record levels and it has been suggested that general practitioners should refer fewer patients. There has also been much publicity about melanomas and the importance of early diagnosis.

The average waiting time for a routine dermatological opinion in the Bournemouth area is about 20 weeks. A significant proportion of those patients referred have an eruption or lesion of uncertain identity. I suggest that general practitioners 'refer' a quality Polaroid photograph attached to a specially designed referral form with all the necessary clinical details. A space on the form would be reserved for the dermatologist's report and recommendations (similar to a cardiologist's report on an electrocardiogram) indicating whether the patient needed to be seen. After completion the form would be returned to the general practitioner.

Such a system could reduce waiting lists, expedite the diagnosis and treatment of simpler problems and possibly lead to the earlier diagnosis of more sinister conditions such as melanomas when appearances are atypical or a general practitioner uncertain.

Whether this system could be extended to other specialties seems doubtful but in dermatology I see no reason why it should not be tried.

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Congratulations

Sir,
I have received a letter from an orthopaedic consultant which reads 'I have replaced over 2000 hips and this is the first time I have had a letter from a GP with congratulations, although I hope this patient is not the only one to do well!' Perhaps hospitals are not the only organizations to fail to communicate.

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