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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