variation alone, subjects selected because they represent an extreme value in a distribution can be expected to have less extreme values on subsequent measurements. That this phenomenon applies to cholesterol was clearly shown in the multiple risk factor intervention trial[1] where there was a significant drop in cholesterol in study subjects between the first and second screening stages, before any intervention took place.

We are concerned that uncontrolled studies of this nature are being widely published, creating the impression that general practitioners are achieving more in the field of prevention than may be the case. We have learned to observe patients with high blood pressure for a period of time before intervening; should we not be doing the same with cholesterol measurements?

The high proportion (13%) of subjects with a cholesterol level greater than 7.8 mM in Dr Jacobs' study raises an interesting problem. The recent policy statement of the European Atherosclerosis Society[2] recommends that referral to a lipid clinic or specialist physician should be considered at this level. We doubt that specialist medical or lipid clinics in the UK could cope with this tremendous increase in workload and it is therefore essential that these patients are properly observed and managed in general practice.

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## Inappropriate use of casualty departments

Sir,

Dr Elizabeth Horder's letter (August *Journal*, p.372) is useful because it pulls together a number of questions about the use of hospital facilities. But the questions themselves may be inappropriate. We must remember that the National Health Service is a demand-led service for patients; it is only a convention of the medical profession that hospital care is secondary.

Dr Horder does not state the overall level of attendances in the casualty department surveyed. Cardiff has had one of the busiest casualty departments in the UK for many years. A numerical survey of attenders made some years ago, in response to a similar complaint, showed that the high level of attenders actually represented one patient per consulting session per general practitioner in the district. While the department was inundated with patients, each general practitioner in the city was unaware of seeing only 19 patients per surgery session instead of the expected 20.

If casualty departments are overloaded in the eyes of their staff and management, it is not because the local general practitioners are work-shy, but because the departments provide a focus of assembly. A better relationship between casualty staff and surrounding practices can be developed if both sides take the trouble to talk to each other. In Cardiff the initiative came from general practice. Stop recriminating and start talking; and keep on talking — every six months.

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Sir,

Elizabeth Horder raises the old question of the inappropriate use of casualty departments. Our group practice was disturbed to find that in a six-month period in 1986[1] one in 25 new consultations took place in the local casualty department rather than in our surgeries. The self-referral rate was 92% (similar to other studies) and on analysis more than 50% of cases could or should have been dealt with in our surgeries. This would have increased each partner's workload by less than two patients each per week.

Many patients attend a casualty department simply because they feel it is more appropriate. Surprise at the size of the numbers highlights general practitioners' ignorance of the extent to which patients receive help from other sources. Dr Horder implies that if general practitioners provided more detailed advice about what they can deal with, if patients could contact a doctor they know with one telephone call, and if general practitioners were more willing to do the work, casualty departments everywhere would be less pressurized. Our practice provides a detailed practice booklet, does not use deputies and has demonstrated that the increase in workload would not be great. We guarantee patients an appointment the same day if they want one and the wait is usually much shorter than in the local casualty department. The patient travels a shorter distance to be seen by a more experienced doctor at the surgery. Yet all this does not help persuade patients to contact us and not go to a casualty department.

Myers[2] showed that patients' perceptions of the general practitioner's ability play an important part in their decision where to attend. Davies[3] demonstrated that more than half of the patients attending a casualty department who were questioned went there because they thought their problem was unsuitable for their general practitioner, or did not want to bother him. Fisher[4] found that 68% of attenders thought their doctor would have sent them to the casualty department anyway, 52% thought they would need an X-ray and only 10% thought their general practitioner would stitch wounds, a finding confirmed by Cartwright[5] and Morgan.[6]

Ignorance, not only of the services offered by some general practitioners but of their availability, can also be demonstrated. Holohan[7] found that 52% of patients asked did not know the practice emergency arrangements and Davies[3] demonstrated that a high proportion attended casualty departments for speed or convenience. Morgan[6] found the main reason was availability of hospital care (32%), with appropriateness (17%) and accessibility (13%) also being important factors. Fisher[4] showed that only 4% of patients preferred hospital doctors. Studies in Sheffield[4] and Newcastle[6] demonstrated that having no general practitioner was a problem in less than 2% of cases, although this may be more of a problem in London,[8] as confirmed by Horder who found that 14% of the attenders were not registered with a doctor.

Patients underestimate the willingness of their doctors to stitch cuts and strap sprains, and exaggerate the likelihood of referral, according to Holohan[7] and Peppiatt.[9] The latter showed that, for all complaints except fractures, head injuries with loss of consciousness and overdoses, 81% of general practitioners felt the patients should contact them.

I suggest this problem has no solution and no matter what action is taken, general practice will always take place in accident and emergency departments. Why then do we try to artificially divide this work and run two separate organizations for emergencies? Why not have one efficient system with general