Dr Conway has reported a patient preference for self-admission when it is thought the family doctor is unlikely to be available. On the other hand half of our self-referrals were examples of self-poisoning and it is our impression that in the city the influence of drink or drugs is a major reason for patients avoiding the usual admission channels.

These two studies suggest that national or even regional admission trends cannot be accurately deduced from single hospital reports. Our experience suggests that the high proportion of self-referrals may not altogether be the result of inadequate family doctor coverage but rather a symptom of change in patient behaviour and attitudes. Whether the deputising service is desirable or not, its standard of medical emergency referral in our district compares favourably with that of the GPs.

PETER D'A SEMPLE

Medical Unit,
Southern General Hospital,
Glasgow

SIR,—Dr Hugh Conway's paper (28 August, p 511) contains much heat but conveys little light on how to deliver primary medical care after hours in urban situations. By his own admission the impetus and justification for his study was his impression of the availability of local general practitioner services, and there is little doubt that his preconceptions have clouded both the design of his project and his interpretation of the results.

In the first place, the study of cases arriving at an acute medical unit does not constitute true appraisal of the primary medical care in a community. In November 1974 working as a GP in an urban area, I saw 546 patients, of whom two were sent to an acute medical receiving unit with a phone call and a letter. This amounted to 0.4% of my primary medical care in that month and illustrates the necessary bias of Dr Conway's view.

Furthermore, the interpretation of his results is a little puzzling. Most of his introduction and discussion revolves round the non-availability of GP services, which he claims is the reason for the high rate of self-referral of patients. Yet it appears that 70% of the patients admitted made no attempt to contact a GP and only 24% reported difficulty in contacting their doctor. One wonders if Dr Conway accepted the patient's word for this or did he try to verify the statement by contacting the doctor concerned? Was any attempt made to ascertain whether social class, intelligence, or being the patient of particular practices was a feature of this group? In fact, if one takes the total number of patients involved, only 6.8% provided unchecked evidence of difficulty in obtaining GP services—a small foundation indeed on which to build the towering edifice of "an entirely hospital-based emergency medical service in urban areas."

The real problem lies not in the non-availability of GP services but in the fact that patients choose not to use these in urban areas. The reason for the increase in this tendency is obvious from Dr Conway's paper. Ninety-five patients were needlessly admitted to an acute medical ward at immense cost because "it was impossible for various reasons not to accept responsibility for the care of the patient." In other words, the medical registrar could not take the responsibility of sending the patient home when, presumably, the GP, had he seen

the patient, would have taken the responsibility of keeping him at home.

If the medical registrar will not take this simple decision, is there any wonder that self-referral is on the increase? The choice is between a crusty old GP who might give you, at best, some pills or, at worst, a flea in your ear and a bright young medical registrar with a back up of ambulance services, ECG, x-rays, and the promise of a proper examination and a bed for the night. The problem is that the less attractive former proposition is the only one that the Health Service can afford. It is therefore a matter of extreme urgency that the consultants involved either delegate the responsibility of discharge to their registrars or come in and do it themselves.

The picture that emerges out of the results is that the family doctors in Paisley are giving a fine service to their patients when they are called upon to give it. I wonder if they receive a letter and a phone call from Dr Conway or his staff when their patients are discharged. That fine service is the foundation on which a good community-based care can and must be built and, from the evidence provided, Paisley needs a few repairs at minimal cost and not the demolition job which is suggested. Urban general practitioners have a difficult enough job operating in deprived areas under difficult conditions without the discouragement which this paper is bound to occasion them.

Lenzie,
Strathclyde

J C MURDOCH

Compulsory seat belts

SIR,—I am astonished by the attitude expressed by Mr J A E Primrose (14 August, p 422) to the compulsory wearing of seat belts. The idea that laws restricting personal freedom or which "the police do not like" "cannot be enforced" is completely negative. Surely, in view of the undoubted facts concerning their use and effects, from Australia and elsewhere, every medical practitioner ought to do his utmost to support both the wearing of belts and the legislation requiring that belts be worn. In particular, if it is true that "the police do not like" seat-belt legislation, which I do not believe is true of all policemen, every effort ought to be made to change that attitude, remembering that it was a US highway policeman who first referred to the "second collision," which occurs when unrestrained car occupants hit the inside of a vehicle which has collided with something else.

Those people who talk about their personal freedom to risk death or serious injury without hindrance should be reminded, gently or otherwise, that many of us would prefer not to be roused from our beds to deal with injuries which are sometimes entirely due to the lack of restraint and, if the subject of belt-induced injuries is raised, also informed that in such cases the victim would almost certainly not have survived without the belts. After years of listening to people prating about their freedom I could not feel greatly concerned about them. What does concern me and ought to concern all those who think about it is the enormous cost of death and injury which falls upon us all in the long run, since the cost is effectively deducted from the gross national product of any country.

Since I now hear that the legislation has been considerably delayed it will be some time

before patients in the UK begin to visit their medical attendants for certificates enabling them to avoid wearing belts. I am not subject to such requests, but one of my colleagues presents a legally drafted "release form" absolving him from all liability for injury or death caused or contributed to by non-use of seat belts for signature by those of his patients who ask for such certificates, whether or not he considers the request reasonable. So far as I am aware only one patient to date has signed the release form and received a certificate. Earlier this year a woman was ejected from a car involved in a collision in Toronto and was then run over and killed by another vehicle. She had a certificate that she was unable to wear seat belts on the ground, so I have heard, that she suffered from claustrophobia. Legal action is, I understand, being taken against the person whose signature is on the certificate. It is obvious that such certificates should be signed only after due regard is paid to the consequences of so doing, as with any other issued by a physician, and my colleague feels that the effort involved in having his lawyer draw up the release form was well worth while.

F B SINGLETON

Kingston,
Ontario

Economy in prescribing

SIR,—As an industrial pharmacist and regular reader of the *BMJ* I feel I must spring to the defence of my colleagues in retail pharmacy who may not have had the opportunity to see Dr J N Graham-Evans's comments about them (4 September, p 585). To presume that the pharmacist (dispensing chemist) is merely a clerk armed with a pocket calculator and automatic electronic tablet counter shows a total ignorance of the work of this honourable profession.

Unlike your correspondent, many members of the public have great faith in their local pharmacist and often a visit to him or her is preferred rather than one to the local general practitioner. The pharmacist does not have a register of patients on which his salary is based and therefore his advice to customers is essentially free. His approachability and accessibility to members of the general public ensure that his advice is freely sought and given. At the moment I can think of no other members of a profession who give their advice in this manner and this is perhaps one of the reasons why pharmacy is not given the due respect it deserves by members of such professions. Another, more obvious, reason for disrespect is a purely financial one. The costs of running a modern day pharmacy are high and because the prescription pricing system ensures an inadequate return for purely professional services retail pharmacy can survive only by the sale of non-medical items. Fortunately, in most circumstances the sale of these items does not detract from the quality of the pharmaceutical services offered.

Most retail pharmacists can recall many harrowing stories about the over-prescribing of medicines, particularly for such products as barbiturates and appetite suppressants, and they have played an active part in counteracting the abuses of these substances. Responsible members of both the pharmaceutical and medical professions are currently co-operating with the DHSS to find more acceptable ways of reducing dispensing costs than those suggested and I am sure that the