pictures of identifiable patients unless we have their permission or the permission of their next of kin. In the case of Tony Bland his parents had given permission for the press to reproduce his picture. They will have had their own reasons for taking that decision, but we believe that publishing a picture of him adds importantly to the information available in words. Some doctors have never seen a patient in a persistent vegetative state.

Another reason for publishing pictures is to distinguish one section of the journal from another. We rarely publish pictures, tables, or graphs in the editorial section, and we do not add pictures to the original papers. We deliberately include them in the news section to give this section a different identity. These pages are designed to look "newsy," which means including pictures. Newspapers carry pictures, and so do journals like *Nature*, *Science*, and the *Economist*. Sometimes these pictures will not be as relevant as we would like. But this problem is experienced by all publications putting together news pages fast.

What J K Anand and J W Myles may not understand is that the *BMJ* is the most general of the world's general medical journals. Few general practitioners read either the *Lancet* or the *New England Journal of Medicine*, and few doctors outside the United States read the weekly, English language edition of *JAMA*. The *BMJ* is read by academic researchers, hospital consultants, general practitioners, and public health doctors all over the world; and increasingly it is read by managers, politicians, health service researchers, patient groups, and people interested in health policy.

We must thus try to produce something for all of these disparate groups, and having distinct sections is one way of achieving this objective. Dr Anand and Mr Myles will not be surprised to learn that few people have enough time to read every word of each issue of the *BMJ*. Many busy doctors skim the journal, dipping in here and there; and our research shows that more will engage with pages that contain pictures. We publish a journal to be read, to inform, and to influence the development of medicine, not simply to be filed on library shelves.—ED, *BMJ*.

Night visiting in general practice

EDITOR,—Chris Salisbury presents an important contribution to the debate about general practitioners' out of hours work and responsibility,[1] highlighting the fivefold increase in night visits in 25 years, the doubling in the rate in the last 10 years, and the fact that the rate will double again by the end of the decade if the reported trend continues. Possible reasons for this, Salisbury concludes, are increasing consumer demand, doctors' increasing willingness to visit (for financial reasons), and the organisation of out of hours work. Brian T Williams states that "the extended hours of eligibility and the greater rewards for general practitioners who make their own night visits readily explain these changes in activity."[2] I dispute this.

Statistics from general practice cooperatives suggest that the main reason for the increase is simply increasing demand. This has considerable implications for manpower and organisation if it is not tackled. I know of no sensible general practitioner who regards night work as an "opportunity to enhance income."[2] Furthermore, any benefits that Williams implies are gained from doctors working harder at night, even if true, are far outweighed by the resulting disruption to the working day, when 98% of our contacts with patients occur.

The establishment of out of hours cooperatives in Kent since 1989, covering 600 general practitioners, has led to the removal of most variables. Maidstone Doctors On Call, for instance, has the same number of principals covering the same number of patients with the same advice rate (39%) as when it started. There is no incentive (or disincentive) for the general practitioner to visit. Despite this the workload has increased steadily by 10% a year. Practices locally not using the service report a similar increase, making the organisational factor irrelevant. I therefore conclude that this increase is due to patient demand.

Thus, although generally agreeing with Salisbury's conclusions, I wish to emphasise the problem of patient demand. I disagree with Salisbury's proposals, which would fuel the inappropriate use of doctors at night. A system already exists that solves the problem of 24 hour commitment—namely, general practice cooperatives, which are non-profit making organisations run and controlled by principals in general practice. Our financial efficiency, response rates, and satisfaction ratings (among patients and doctors) are good. Fortunately, some family health services authorities (and possibly even the Department of Health) are waking up to this. The General Medical Services Committee is a long way behind and must do more than just ask the department to clarify the differences between cooperatives and deputising services. Both must put cooperatives at the top of the agenda in their negotiations.

Whatever the system, the harsh truth is that some disincentive, not necessarily financial, will need to be introduced to put the brake on the accelerating inappropriate use by the "consumer." Perhaps education is the key, but I doubt it. Maybe this is to become part of the debate on rationing, which the citizen's charter contradicts.

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1 Salisbury C. Visiting through the night. *BMJ* 1993;**306**:762-4. (20 March.)
2 Williams BT. Night visits in general practice. *BMJ* 1993;**306**: 734-5. (20 March.)

EDITOR,—Chris Salisbury concludes that reorganisation will become essential if the number of night visits made by general practitioners doubles again. Salisbury reports that general practitioners in Berkshire claimed for 31·5 night visits per 1000 population in the payment year to September 1992.

In the year 1992-3, 647 night visits were made in my inner city practice, a rate of 59·6 per 1000 patients. The total rate of out of hours contact was 246·7 per 1000 patients (1900-0700 weekdays; 1200 Saturdays to 0700 Mondays; 0700 to 0700 bank holidays). Our 10 855 patients, 30% of whom attract medium rate deprivation payments, consulted us on average 6·14 times each during the year.

Some of us think that a reorganisation of night visiting has been essential for some time.

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1 Salisbury C. Visiting through the night. *BMJ* 1993;**306**:762-4. (20 March.)

EDITOR,—Brian T Williams's editorial on night visits in general practice is disappointing.[1] It mentions "greater rewards for general practitioners who make their own night visits" whereas the effect of the new contract was to penalise each doctor by £30 for any visit undertaken by a colleague in a rota of more than 10 doctors.

General practitioners do not value the "opportunity to enhance income through night visits," and this opportunity does not "soften less agreeable effects of practice with the contract." The system of average net remuneration should be well known to Williams, but this is not apparent from his editorial.

Williams concludes that it is as yet unknown whether more night visiting has resulted in better clinical decision making. Can we occasionally use common sense rather than rely on an elusive search for proof or knowledge? A family doctor's clinical decision making, as well as all the other qualities of potential benefit to the 30 to 60 patients he or she may see in a day, is not enhanced by the prospect or the reality of regular disturbed nights. The search for ways of easing this burden is of prime importance to most general practitioners. The night visit aspect of the new contract was a backward step in this respect, and Williams's editorial was, to say the least, a "heartsink" article.

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1 Williams BT. Night visits in general practice. *BMJ* 1993;**306**: 734-5. (20 March.)

EDITOR,—Chris Salisbury makes the assumption that since there has been an increase in claims for night visits (over and above that expected because of the increase in the number of hours during which visits can be claimed) general practitioners must be performing more night visits.[1] Might practitioners not simply be submitting more claims?

Since the reduction of the basic practice allowance and supplementary capitation fees the income from night visit fees has assumed greater importance in maintaining a practice's income (1·9% of our practice's income came from night visits in 1988-9 compared with 4·9% in 1990-1). The large increase in the night visit fee to £45 is in itself an incentive to submit claims. In addition, since the introduction of the contract in 1990 practices have increased their organisation, employed more staff, and become more financially oriented. This would result in fewer visits being unclaimed for.

We believe that because of these biases a study looking at claims may underestimate the number of night visits made before the new contract was introduced. Indeed, this may explain the apparent increase in night visits under the new contract. A study should look at actual night visits rather than claims before it can be concluded that demand for night visits is accelerating.

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1 Salisbury C. Visiting through the night. *BMJ* 1993;**306**:762-4. (20 March.)

EDITOR,—As I was a general practitioner for over 45 years, 30 of which I spent in Berkshire, I was interested in Chris Salisbury's paper on patients' increasing demands for night visits.[1]

In 1967 I would have been called out about nine times in a year to see patients in the middle of the night. I would have earned an income broadly similar to that of a solicitor (BMA economic research unit). I would have been both distressed and alarmed at receiving a complaint from the executive council. An assault on a general practitioner was unheard of. In 1993, if I were still in practice, I could expect to be called out 42 times a year to see patients in the middle of the night. I would earn 55% less than a solicitor (BMA economic research unit). I would receive a complaint about my care from the family health services authority every three and a half years[2] and would regard assault by a patient as an occupational hazard.[3]

It seems that, compared with my generation, general practitioners today are overworked, over-