1 Cragg DK, Campbell SM, Roland MO. Out of hours primary care centres: characteristics of those attending and declining to attend. *BMJ* 1994;**309**:1627-9. (17 December.)

Two tier fee for night visits preferred

EDITOR,—As I understand it, the General Medical Services Committee recently rejected the proposals concerning out of hours work on the basis of the costing of the deal. The GMSC is still committed to the principle of any new deal that includes a single fee for night visits. My partnership believes that this approach should be abandoned and is prepared to resign from the BMA should the GMSC persist with it. It is patently unreasonable to expect general practitioners who have no choice but to do their own night visits to subsidise those general practitioners who can choose other ways to provide out of hours cover. At least the previous two tier fee for night visits offered a reasonable differential in recognition of work done. I believe that Brian Hurwitz's point regarding the GMSC's rejection of the proposals is not entirely accurate.[1]

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1 Hurwitz B. Out of hours. *BMJ* 1994;**309**:1593-4. (17 December.)

Guidelines are needed on when to visit

EDITOR,—I share Brian Hurwitz's scepticism that emergency centres will become realistic alternatives to home visits.[1] Despite 69% of British households having access to at least one car or van[2] difficulties with transport are not easily overcome. There is a cultural gap between the public, who desire increasing convenience, and general practitioners, who personally (and understandably) want to be inconvenienced less—as much as anything so that they can provide a more efficient service in normal hours. Having to reconcile patients' rights as stated in the patient's charter and notions of appropriateness and efficiency is difficult.

Changes to paragraph 13 of general practitioners' terms of service do not ease this difficulty. They require general practitioners to decide in the light of the patient's medical condition whether a consultation is needed and, if it is, when and where. Such decisions are to be based on the doctor's reasonable opinion. Patients may, however, have a different view of what is reasonable—as evidenced by the charge of "failure to visit" being one of the most common reasons for general practitioners appearing before a service committee.[3] To date there seems to be little published research to guide general practitioners in making decisions on out of hours visits. A small study of 14 general practitioners in a London health centre reported that "a potentially serious diagnosis" was the reason most commonly given for visiting and that the decision to visit less clear cut cases was based not on medical factors but on the expectations of patients and non-medical needs.[4]

I am investigating general practitioners' opinions concerning the factors that influence decisions about home visits out of hours. One useful output of the research may be to inform the development of guidelines.[5] The first phase is a large survey of general practitioners in three family health services authority areas in the west midlands. The second phase entails interviewing general practitioners with the critical incident technique in association with the department of general practice, University of Birmingham (the public's perspective may also be explored through use of this technique). The contributions of the quantitative and qualitative methods will be evaluated. Comments, advice, or, indeed, general practitioner volunteers for the interviews are welcomed.

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1 Hurwitz B. Out of hours. *BMJ* 1994;**309**:1593-4. (17 December.)
2 Office of Population Censuses and Surveys. *General household survey 1992*. London: HMSO, 1994. (Series GHS No 23.)
3 O'Dowd T, Sinclair H. Open all hours: night visits in general practice. *BMJ* 1994;**308**:1386.
4 Cubitt T, Tobias G. Out of hours calls in general practice: does the doctor's attitude alter patient demands? *BMJ* 1983;**287**: 28-30.
5 Feder G. Practice guidelines and practical judgement. *Br J Gen Pract* 1994;**44**:592.

Establish primary care centres in hospitals

EDITOR,—I believe that David K Cragg and colleagues' conclusion that most patients are either not able or not prepared to attend a primary care facility may be flawed.[1] Their population does not include all patients who seek primary care out of hours: many patients bypass their general practitioner and deputising services and go to their local accident and emergency department. Many patients seen at accident and emergency departments could be treated at primary care centres.

It would therefore seem sensible to amalgamate primary care centres and accident and emergency departments, particularly in urban areas.[2] Such a centre would still be able to provide home visits or send an ambulance to transfer patients to the hospital if required. The main obstacle to the formation of such integrated primary care centres in hospitals is funding. If this could be overcome then doctors providing the full range of primary care out of hours and those patients requiring it would meet in the same place.

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1 Cragg DK, Campbell SM, Roland MO. Out of hours primary care centres: characteristics of those attending and declining to attend. *BMJ* 1994;**309**:1627-9. (17 December.)
2 Kumar K, Olney DB. Primary care emergency services. *BMJ* 1994;**309**:199.

Consequences of GPs opting out

EDITOR,—I wonder what objective Dr Ian Bogle has in warning the Department of Health that, as a consequence of his pay offer for out of hours work, he cannot guarantee that general practitioners will retain their 24 hour commitment.[1] When using threat in negotiations it is normal to threaten something that the other side would not like to happen. Is Dr Bogle sure that the Department of Health wishes general practitioners to maintain 24 hour cover at any cost?

Admittedly, the cost of employing general practitioners outside general medical services to be available out of hours would be prohibitive. What, however, would the government do if general practitioners opted out en masse? It might employ salaried practitioners (not necessarily doctors) to be on call; staff emergency centres out of hours to receive all those patients who could get there; set up a new mobile paramedic service to treat out of hours callers or transport them to emergency centres, community hospitals, or accident and emergency departments; carry out market testing (surely fundholders, community units, and the private sector would be interested); or charge those not receiving benefit a fee for out of hours calls. The possibilities are endless.

And where would the government and history most probably lay the blame? Well, it was the general practitioners' decision to opt out; the government did not want to end general practice as we know it. And the headline? "GPs in 1996 undo 1966."

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1 Beecham L. Out of hours deal rejected by general practitioners. *BMJ* 1994;**309**:1392. (26 November.)

Results of survey of general practitioners' opinion

EDITOR,—As a result of the recent discussions between the Department of Health and the General Medical Services Committee about the payment for out of hours work there has been a considerable reaction from general practitioners in Cumbria, particularly after the publication of the department's offer of £2000 a year plus £9 a visit between the hours of 2200 and 0800. Cumbria has a higher than average out of hours workload, with a rate of night visits of 40/1000 patients/year (the mean for England and Wales is 35·3[1]). It has a mixture of relatively deprived urban and dispersed rural practices with no possibility of using deputising services. Consequently most practices stood to lose financially from the proposed deal, without an opportunity of being relieved of any of the burden.

After discussion by the local medical committee the 318 Cumbrian principals were sent voting forms listing five options: (*a*) no change; (*b*) renegotiation of the present budget for night fees to allow local arrangements; (*c*) negotiation to increase the proportion of funding for general medical services used for night fees within the present budget for general medical services (and to reduce other components); (*d*) negotiation to increase the total budget for general medical services to increase night fees, backed with a realistic threat of sanctions; and (*e*) introduction of fees for night visits. The general practitioners were asked to indicate, in order of preference, all the choices that they wished to support. Altogether 163 replies (51%) were received. The table gives the results. Option (*d*) was the most popular and option (*b*) the next most popular. Those wishing to retain the present arrangements were outnumbered by those who did not indicate this option at all. After redistribution of the votes for the less favoured options under the single transferable vote system, option (*d*) retained its lead over option (*b*) (39% *v* 36%).

General practitioners' preferences regarding payments for night visits

Option*	No of no votes	Choice 1st	2nd	3rd	4th	5th
(*a*)	43	30	40	27	15	8
(*b*)	38	51	45	17	10	2
(*c*)	82	15	15	18	21	12
(*d*)	44	62	20	19	14	4
(*e*)	88	4	5	18	11	37

*See text for details.

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1 Hallam L, Cragg D. Organisation of primary care services outside normal working hours. *BMJ* 1994;**309**:1621-3. (17 December.)

Correction

Secrecy in the NHS

An authors' error occurred in the letter by Sian Griffiths and colleagues at Oxfordshire Health Authority (21 January, p 191). Nicholas Hicks, consultant public health physician, should have been listed as an author.