1974, has 400 beds and 10 outlying clinics and is situated in north-east Transvaal. It is well equipped with a good X-ray department, laboratory, pharmacy and central surgical supplies department and well-qualified paramedical staff to run them.

The hospital is the only medical service for a population of over 200 000 who are mainly black, but whites are also treated and admitted, there being no discrimination according to race in the homeland hospitals. A year ago this population was cared for by nine full-time doctors, now there is only one elderly doctor remaining. Two neighbouring hospitals have no full-time doctors and a similar situation prevails in many rural areas.

Three thousand outpatients and 200 deliveries a month as well as 400 inpatients is obviously too much for one doctor to cope with. Tuberculosis, typhoid, venereal disease, ectopic pregnancy, obstructed labour, eclampsia, stab wounds and car accidents are all common and there will be many avoidable deaths.

Working in a rural area in South Africa provides valuable experience for a doctor because there are many seriously ill patients, and because the infrastructure, supplies and so on, are much better than in many other 'developing' countries. Any doctors going to work in such a hospital in the present situation will benefit themselves and their patients greatly.

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Who owns the patient's record?

Sir,

Dr Marshall Marinker in his editorial (October *Journal,* p.442) raises some important issues relating less to the matter of ownership of the record than to access to the record.

I am very much in favour of patients having access to their records, with the proviso that this should be initiated in the presence of the doctor. Under these circumstances any misconceptions on the part of the patient can be cleared up immediately and the arguments against access are less persuasive. The patient's understanding of the data can be checked and intellectual or emotional problems diffused.

Doctors necessarily tolerate uncertainty, take small but acceptable risks, and record opinions and best guesses in patients' records. All these matters should be conveyed to patients in the course of management so that recording them represents no difference from the usual situation. If these matters are not discussed with patients then it is usually to their disadvantage. If doctors do not wish to disclose part of their interpretation about patients then they need not record this in their record. If they feel it is important enough to record then it might be important enough for the patient to know about.

The only argument against open access which really seems cogent relates to information derived from or about a third party. It should be possible to devise a system which avoids problems arising from this.

I hope that there is considerable debate about this matter. It is, as Dr Marinker rightly says, an ethical issue, but it also is of very great importance to quality of care.

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Restrictions on trainees applying for single-handed vacancies

Sir,

I should like to bring to the attention of trainees and trainers a legal ruling concerning single-handed practice vacancies which seems not to be well known. I finished my vocational training in January 1987 and was encouraged to apply for a single-handed vacancy which commenced in March 1987. My previous single-handed experience in the Royal Army Medical Corps seemed to make me a suitable candidate.

However, my application was deemed invalid because I would not possess a Certificate of Prescribed/Equivalent Experience at the time the Medical Practices Committee made their selection, even though I would have it by the time the post commenced. Since no one in the West Cumbria scheme was aware of this, I wrote to the MPC who confirmed the ruling under the National Health Service Act 1977 (Section 31 (1) (a)). I would hope that other trainees could avoid the disappointment I had suffered by realizing that they cannot be considered for a single-handed vacancy until they possess a current certificate.

I feel saddened by this ruling, but others must consider the possibility of change.

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Video recording in general practice

Sir,

I was disturbed to read Servant and Matheson's paper (December *Journal,* p.555) concerning the reluctance of their patients to consent to video recording of their consultations, as it runs contrary to my experience. Their low acceptance rate of only 6% makes me wonder why their experience is so different from mine and that of the others they quoted.

Of course, it may be that their patients are genuinely more resistant to this intrusive technology. Alternatively, something in the design of their study may have led to a falsely high refusal rate. May I suggest that it was the use of 'large notices placed upon the waiting room table' drawing attention to the fact that video recording was in progress.

My practice recently had a similar experience when we agreed to participate in a multicentre study and a researcher placed a large notice along similar lines in our waiting room. This caused a great deal of consternation among our patients and one patient was so distressed that she left before the consultation took place. This is in total contrast to their behaviour when, following our usual practice of many years, they are given a verbal explanation by the receptionist of what is about to happen and a form on which to consent to the procedure. Informed consent is thus achieved not by coercion, but rather by allaying natural fears and anxieties. Which of us was not anxious when first being video recorded?

Natural hesitancy can easily be transformed into refusal by factors that increase the anxiety level. One observation we have made is that when patients are asked to consent to this procedure with a new trainee in the practice, the refusal rate rises dramatically. As the trainee becomes more established the refusal rate drops.

I hope that the two illustrations above demonstrate the way in which apparently small factors can have a dramatic effect on the acceptability of video recording to patients. A high rate of consent represents a low level of anxiety and not coercion.

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