

employment extending for five to six years during the first 10 years after qualification, depending on family circumstances. In the long term, however, this simply means that the 25-year-old male graduate has a potential career of 40 years, while the 25-year-old female graduate has a potential career of 35 years. We would be unwise either to disregard the investment we have made in these young women or to underestimate their skill and determination in ultimately following their career full time. I am afraid that Dr McKinlay's aspirations for the employment of young female doctors in any scheme arising out of the General Medical Service Committee (GMSC) Report for 1984,<sup>2</sup> are totally misleading. The report seeks to address itself to the specific problem of lack of time off for professional and personal refreshment among obligatorily single handed isolated practitioners. The report makes it clear that such doctors practice in considerable personal and professional isolation. As chairman of the Scottish GMSC's Rural Practice Subcommittee I have been involved in identifying such practices and quantifying their needs. The solution of their problems is not yet clear but various proposals exist, including the provision of locum services. Such locums however would be few in number, would be required to work in the same isolated conditions and cope with the same rigours of terrain and climate as the full-time principals and at all times of the year. This is not an exercise in 'jobs for the boys' far less in 'jobs for the part-time girls'.

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#### References

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2. General Medical Services Committee. *Single handed practice — a GMSC discussion document. Appendix III. GMSC Annual Report*. London: British Medical Association, 1984.

## Video cameras in the consulting room

Sir,

The paper entitled 'The reactions of patients to a video camera in the consulting room' by E. Martin and P.M.L. Martin (November *Journal*, p.607) described a survey of 637 consultations. The authors expressed concern about the higher than previously reported refusal rate (13 per cent) by patients, and that 16 per cent of patients disapproved of the use of videos. They also show that patients are more likely to refuse (20 per cent) when given a consent form to complete before the consultation, than when asked by the doctor himself (four per cent) on entering his surgery.

As 21 per cent of patients felt the video made the consultation less confidential, and 11 per cent said they were made nervous by its presence, these results are highly likely to underestimate the patients' true feelings. It is therefore surprising that the authors failed to make any recommendations based on their results. From their results I think it would be quite reasonable to recommend that before the use of a video camera in the consultation, patients should be given adequate warning (perhaps a minimum of 24 hours) and time to complete a consent form. This would be given to the receptionist who would then inform the doctor of the patient's decision.

A doctor's first responsibility must be to the patient and teaching commitments must come second.

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## Computers in general practice

Sir,

I was interested in the review of the use of computers in general practice from the Sheffield team (December *Journal*, p.649). There is little doubt that the Sheffield experiment has provided the first properly analysed and documented implementation of general practice computerization.

They comment on the variation in usage of the computer during the consultation. In my experience doctors will only use a computer for record keeping if it is easy to enter and inspect the information. In many computer systems the designers have paid too little attention to this aspect and the screen bears no relationship to the needs of the doctor. Massively structured screens and multiple menus do not fit into most doctors' way of working.

They comment that non-directive doctors found the computer terminal intruded into the consultation. As one who regards himself as non-directive I found that the terminal did not intrude as long as a great deal of thought was given to its position. If the terminal is placed on the doctor's desk it tends to dominate the whole consulting room. If, as many do, the terminal is placed on the side of the desk away from the patient the doctor's attention is continually distracted from the patient. I found that, with the patient sitting at the side of the desk, the best place for the terminal was on a low table on the other side of the patient. Thus the patient sits between the desk and the terminal. In this position the terminal is low enough not to intrude and the doctor is always looking in the same direction. The computer then becomes part of the consultation with the patient involved in his records to the extent decided by the doctor.

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Sir,

Reading the article on the use of computers during the consultation by Herzmark and colleagues (December *Journal*, p.649) two thoughts struck me. First, though the type of visual display units (VDUs) used in the study was not specified, I presume they were of the standard type, that is, resembling a large television. The sight of such a monstrosity on the desk must adversely affect the doctor-patient relationship (though this has not been revealed by the studies to date exploring patient reactions to computers in the consulting room). I wonder if a VDU built into the desk in the manner of the video games one sees, for example, in public houses would be an improvement. I feel that a recessed keyboard, which bears a closer resemblance to the present pen and notepad, might be found to be less intrusive by doctor and patient.

The second thought that struck me is on the more general question of increasing the acceptability of computers to doctors. Given that methods of communicating with computers other than a keyboard are unlikely to be developed in the foreseeable future,<sup>1</sup> would it be worth considering teaching our medical students, or trainees keyboarding skills?

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#### Reference

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