legitimizing job absences through illness. Again, the explanation is not entirely convincing. However, the explanations are not mutually exclusive and they may lend themselves to some higher order generalizations.

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Sir,

We wish to reassure Dr Taylor that we did not overlook the possible influence of the attainments and skills possessed by the study subjects. As we cite in our first paper[1] employees were only included in the study if they were 'blue collar' or low-grade clerical. There is no reason to think that one group is more or less 'skilled' than the other within the sample studied.

In fact the study findings of Dr Martin might carry greater risk of misinterpretation than ours. On the data presented, Dr Martin does not seem to have catered for the effect of job-tenure and our findings suggest that he should have done. More worrying is the fact that his approach was cross-sectional and not (as ours) longitudinal so that to compare the two studies directly is not strictly valid.

However, we value the thought and discussion that this correspondence has engendered. It highlights once again the major influence that life-events have on the health of individuals. As general practitioners we really cannot afford to leave this topic so unresearched. In both studies quoted there are detectable changes in patients' health at least three years after (and also before) a crisis. Would the infliction of a further adversity during this interval simply be additive or might it have explosive potential? As usual, research raises more ghosts than it lays.

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Clinical psychology and primary care: patients' views on the venue for appointments

Sir,

In the last few years clinical psychologists have increasingly taken direct referrals from general practitioners, a move which has been viewed as fruitful by members of both professions.[1,2]

Within clinical psychology there has been debate over whether the outpatient clinic of a psychiatric hospital (where most psychology departments have their administrative base) or the patients' surgery/health centre is the most appropriate venue for a clinical psychologist to see such patients. Our own research (Blakey R, Crawford JR, Taylor R, unpublished results) has indicated that general practitioners are also divided on this issue with 70% favouring health centres/surgeries and 30% an outpatient department.

Proponents for both sides of the debate have commonly cited the putative views of patients in support of their position. Thus those who favour a local health centre/surgery venue have argued that patients feel more secure in such a setting and find it more convenient and less stigmatizing. Patients' concern about stigma has also featured in the arguments of those who have expressed reservations about a health centre/surgery venue. Philip[3] for example, has argued that patients may welcome the anonymity of an outpatient department because it reduces embarrassment and fear of stigma.

We decided to examine the validity of these arguments by means of a questionnaire distributed to patients of the clinical psychology adult service in Aberdeen.[4] The questionnaire asked patients to indicate at which of three venues they would have preferred to attend appointments; (1) the outpatient department of a local psychiatric hospital, (2) their local health centre/surgery or (3) the outpatient department of a general hospital. A fourth option, 'no particular preference', was also available. Patients were also asked if they would have refused to attend appointments at any of the venues.

Eighty two patients took part in the study. Half were currently attending a psychiatric hospital outpatient department, the other half a health centre or surgery. The majority of subjects (56%) recorded a preference for a local health centre/surgery venue whereas only 12% preferred the psychiatric outpatient clinic and 5% the general hospital clinic. The figures were 77%, 17% and 7% respectively when those who had no preference were excluded.

When the responses of clients attending the psychiatric outpatient clinic were examined separately, it was revealed that 43% would have preferred to be seen elsewhere and that 37% (56% of those who expressed a preference) would have preferred to be seen at a health centre/surgery. In contrast none of the patients attending a health centre/surgery would have preferred to be seen at the psychiatric outpatient clinic. Furthermore, as almost half (46%) of the patients attending a health centre/surgery indicated they would have refused an appointment at a psychiatric outpatient clinic, it would appear that not only was a health centre more popular but there was active resistance to the psychiatric outpatient clinic. As only 5% of the total sample would have refused a health centre/surgery appointment the health centre was almost universally acceptable.

These results lend support to the view that clinical psychology appointments should, where possible, take place in the patient's local health centre/surgery. Such an arrangement, in addition to being the most acceptable option for the majority of patients, allows closer contact between the general practitioner and clinical psychologist. This can clearly be beneficial in the management of individual patients and can also, in our experience, encourage fruitful collaborative research and innovations in service provision.

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Computers in practice — whither goest we?

Sir,

In 1981 I approached computerization in my practice with a mixture of enthusiasm and trepidation. Enthusiasm, as I saw the undoubted benefits of increasing computer use by banks, industry and retail shops. Trepidation, as most electrical gadgets I have been persuaded to buy fail to work for me in the same way as for the adept salesman.

I visited the British Medical Association's exhibition at Olympia and was convinced by the professionals of the simplicity and potential of computer use in practice. Several visits to user practices, seminars and group discussions later, I joined, cheque book in hand, the Department of Industry 'Micros for GPs' scheme.