had hypertension, and the average person today knows that hypertension means a risk of stroke or heart attack. They also knew that they were not getting any treatment so it is not surprising that their blood pressure did not settle.

To undertake such a trial, the general practitioner must have been enthusiastic about weight reduction. Conversely, he must have been pessimistic about the approach taken with the control group and the patients would have noticed this. As an extra point, the general practitioner, not an independent observer, followed up these patients. All of these factors must bias the results.

What happened after this six-month period? Did the doctor tell the patients that they should now lose weight, stop smoking, take exercise and possibly take tablets? Did the patients who had wanted to lose weight still want to lose weight now that the doctor had decided it was time to educate them and treat their condition?

I suggest that he was six months too late.

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Sir,
The average patient may or may not know that hypertension means a risk of stroke and heart attack. Most patients with blood pressure in the range systolic 140–200 mmHg, diastolic 90–114 mmHg do not experience early morbidity or death attributable to hypertension, and hypotensive drugs have significant side-effects, an unknown future and are more easily started than stopped. The Medical Research Council's trial of the treatment of mild hypertensives[1] has not produced a clear case for immediate treatment but has underlined the importance of continued follow-up. To say that we omitted treatment assumes that I share Dr Hay's views on first-line management and I suspect that I do not. A positive approach can mean finding out what the patient knows, providing a reasoned discussion about risks, assessing blood pressure over a period in the hope that it may fall, and being reluctant to rush for the prescription pad. This was our approach to both hypertensive groups.

Since the two groups were given similar advice about salt and alcohol, Dr Hay must feel that it was unethical to withhold dietary advice from the control patients. At the time of our study there had been no randomized controlled trials of weight reduction in untreated hypertensive patients and no general practice study to assess its usefulness. It seems reasonable to ask if ideas which are commonly promoted are effective in practice.

We accepted in our discussion that enthusiasm (of dietitians and patients as well as the doctor) may bias interpretation of the results. This limits conclusions about the precise effect of calorie restriction but does not alter the broader conclusion about the usefulness of the intervention.

Stopping smoking is not a method of lowering blood pressure. If we had opted to give advice against smoking we would have had to be serious about it and expect it to be successful — and expect weight gain. We chose to defer advice for a period during which the focus was on weight and blood pressure. Since the results of the MRC trial[1] have shown that giving up smoking is far more important than reduction of blood pressure to the smoking hypertensive in terms of the risks of hypertension, I would now agree that randomization should follow smoking advice and the benefits of dieting studied in that context.

The patients in the control group had a low dropout rate at six months. Many were judged not to need specific therapy but attended for further checks periodically and all smokers received advice. The five patients who had proposed to diet, contrary to Dr Hay's prediction, lost more weight than the treatment group and they were later joined by others now advised to lose weight. Their good attendance continued. Why?

Perhaps we were six months too early in the treatment group.

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Reference

1. Medical Research Council Working Party. MRC trial of treatment of mild hypertension: principal results. *Br Med J* 1985; **291**: 97-104.

The age of the computer?

Sir,
I read with interest the editorial on computers by Alan McWilliams (November *Journal,* p.490). He has clearly identified some important issues facing general practitioners planning to invest in computerization.

At VAMP we are aware of the problems of obsolescence and feel that a practice investing in computerization should be sure that: (1) they will get the full performance and natural life out of the computer hardware that they purchase; (2) their software has a long term growth path; and (3) the investment of time and effort in getting the practice data onto the computer will not be written off because future hardware or software developments are incompatible with their current system. These are the issues that McWilliams addresses and to overcome them is a tall order from a technical point of view.

Of the three strategies outlined by McWilliams we have rejected the 'throw-away' strategy and adopted a combination of the 'upgrade' and 'network' strategies. They key to this is in an operating system, Business Operating Software (BOS) and BOS/LAN which is the BOS local area network. This system can operate on over 50 makes of personal and mini computers and allows users to add additional hard discs, screens and printers. Even so, the policy of upgrading has its limitations and the capacity of the purchased computer may be used up before its natural life has expired. A network strategy avoids this problem by allowing the addition of more computers which can then run together.

The result of this 'upgrade' plus 'network' strategy is that practices can invest in suitable systems for their perceived short/medium term needs. In our case this would be a VAMP multi-user system capable of being upgraded by increasing the storage capacity or the number of screens and printers. However, practices can upgrade their systems in the knowledge that they can take advantage of new developments in hardware or software when they become available by adding the new hardware and software needed under the network without needing to throw out the existing system.

Networking alone is no substitute for a good multi-user system in price or performance, but a multi-user system needs a networking option to keep the customer options open as no one can forecast the rate of change in this area.

PETER WILLIAMS

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Video recording in general practice

Sir,
The article by Servant and Matheson on video recording (December *Journal,* p.555) raises several important issues.

While not explicitly stated, this study aimed to examine consent to video recording in patients who were not asked directly by doctors or reception staff. The prior assumptions were, first, that consent by a direct interview with the patient is inevitably biased and thus 'coercive' but that the extent of any coercion can be minimized by explanation of the procedure by a letter given to the patients in the waiting room, and secondly, that this procedure would provide a means of obtaining informed consent. Using two methods of obtaining informed consent based on letters, low rates of consent were obtained. From this overall result the authors conclude that video recording of consultations is not acceptable to patients. However, they give no indication as to whether the patients understood the information given to them — was the consent, or in this case refusal, informed? Understanding the information given is clearly an issue central to the notion of informed consent and to this study. Many factors, other than acceptability, could account for their findings. For example, did the patients actually read the letter, or was it phrased in an unclear or ambivalent manner? It is impossible to judge the clarity of the letters as few details of the information given to the patient are presented in the paper.

Servant and Matheson's paper raises two issues that are central to the video recording of consultations — 'procedural justice' (fair and just procedures) and 'substantive justice' (equity). Procedural justice, in this case, refers to the means of obtaining consent. In attempting to protect their patients against coercion Servant and Matheson may have rejected people who would have consented if they had been properly informed. The studies with high rates of consent may accept people who would not have consented in less biased circumstances. Both these errors are errors of substantive justice. An important feature of equity lies in its concern for the individual and the common good — in this case, is the video recording of future benefit to the patient? If this is the case then the procedures used by Servant and Matheson do not result in an equitable outcome. It must be remembered that the patients involved are not of marginal status in society, for example prison inmates, and that video recording is not a physically invasive or high risk procedure. Thus, the criticism levelled at other workers of using coercive techniques may be misleading, since patients may be willing to engage in behaviour that may not be acceptable in other circumstances, if it can be seen as contributing to the common good. It is clear that a balance must be struck in selection as the preoccupation with proper procedures can lead to the errors of equity outlined above.

These issues, among others, are of importance in the consent procedures used in medical settings. We have been engaged in research in several practices over the last year using video tapes of consecutive consultations. The patient is provided with written information about the research and the video procedure and is asked to sign a consent form. One of us (A.P.B.) is available to answer queries and speaks to the majority of the patients. This procedure appears to be acceptable to the patients and the general practitioners involved. Over 800 patients have been approached and the acceptance rate is around 80%. Many patients express positive feelings towards the procedure and actively engage in the spirit of the venture. It would be difficult to accuse us of being coercive.

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Sir,
The survey carried out by Servant and Matheson purported to examine the consent rate of patients to video recording of consultations in two separate studies. The overall consent rate for the two studies was 10% — 22% in one, 6% in the other.

The chief part of the investigation appeared to be based on a letter left for patients in the waiting area. Though the letter was not published the article does state that in it patients were asked 'to return the form to the receptionists if they would like their consultation to be recorded'. The conclusion of the article was 'Taking consent rates to being filmed as an indication of patient acceptability, it is clear from this study that patients do mind'. A good deal of effort by the patient was required and Drs Servant and Matheson were in fact asking their patients to volunteer to be filmed — a far cry from merely consenting to be filmed.

It is not therefore clear from the survey that patients do mind being filmed. What they do mind is being asked to volunteer to be filmed. As a contribution to the literature the article would have been much more useful had this important distinction been made clear in both the title and in the conclusions.

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[*The texts of the two letters left in the waiting room for patients were provided by the authors but were not included in the published version. Ed.*]

Nurse practitioners

Sir,
I read with interest the leaflet from the National Association for Patient Participation which was enclosed with the December issue of the *Journal* as I believe it is important for us to be in touch with our patients' needs and views.

However, I was surprised at some of the statements made by Barbara Stilwell in her article about nurse practitioners. Although I agree that medicine is often disease oriented, I have always felt that the great attraction of general practice is that we do have personal contact with our patients and can help to combat the effects of illness on their lives. I also feel that a major part of our work involves providing a listening ear and that we are spending an increasing amount of time on health education and disease prevention. I am sure that Ms Stilwell will agree that practices which are enthusiastic enough to employ a nurse practitioner will be the very ones most concerned with these aspects of their patient care.

I found her comments rather divisive and felt it would have been more appropriate for her to suggest that nurse practitioners could work together with general practitioners to provide health education, a listening ear and so on instead of offering this as an alternative service.

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Future general practice

Sir,
The article on general practitioner beds in Finland by Roger Jones (January *Journal*, p.28) is timely. The provision of beds at health centres in Finland is but one aspect of the Finnish situation which is worth further examination by doctors in