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.

A.P. BOARDMAN
T.K.J. CRAIG

National Unit for Psychiatric Research and Development
Lewisham Hospital
Lewisham High Street
London SE13 6LH

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.

H.A.F. MACKAY

4 Birtley Lane
Birtley
Tyne and Wear DH3 1AX

[*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.

JILLIAN M. MORRISON

Department of General Practice
Woodside Health Centre
Barr Street
Glasgow G20 7LR

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