and Matheson (December *Journal,* p.555) for having prominently advertised the presence of video equipment in their surgery, stating that this may have led to undue anxiety among patients and a higher refusal rate. Surely our priority in general practice is our patients' health not their television performances?

I pointed out in 1985[1] that there was at least one alternative interpretation of the statistics being presented in support of the use of video recordings, and also expressed concern at the methods being used to obtain patients' consent. Servant and Matheson's paper confirms my fears and surely indicates that much greater care should be exercised in designing an acceptable protocol for the use of video recording, that is, unless we want to see today's patient having to carry an Equity card.

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Reference

1. Perkins PD. Video cameras in the consulting room. *J R Coll Gen Pract* 1985; **35:** 151.

Sir,

Servant and Matheson concluded from their recent study (December *Journal,* p.555) that most patients object to their consultations being video recorded, and that high levels of consent are only obtained by coercive methods. Their data do not, however, appear to support their conclusion, but merely demonstrate the well-known fact that if you ask people to act positively about something which does not directly benefit them, most people usually do not.

The vital difference between opting in and opting out has long been recognized, for example, in relation to political levies by trade unions. The overall impression from Servant and Matheson's data and the other studies they cite seems to be that a few patients are enthusiastic to be filmed, a few object, and the majority are not greatly concerned either way. This reflects the experience of our department in video recording with medical students.

Their paper raises important ethical issues. Most patients would like to be seen by the doctor of their choice at a time and place and in the circumstances of their choice. However, this has to be balanced against other considerations, including the needs of undergraduate and postgraduate medical education. Many patients recognize this, and are prepared to submit to the inconvenience of seeing students and trainees who are being video recorded. It is patients and patients' organizations who most often complain about doctors' poor communication skills. If properly informed, therefore, they are likely to agree to help with teaching techniques which have been shown to improve these skills. Although patients must consent freely to take part in this teaching, it would be short-sighted to lose a valuable teaching method which can improve services to patients because of a hastily formed judgement.

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Workload in general practice

Sir,

I have read the letters of Dr Rutledge and Drs Phillips, Hood, Jary and Cox (January *Journal,* p.40) concerning the paper by Drs Fry and Dillane (September *Journal,* p.403) and the question of workload in general practice. They mention the importance of social factors on workload — Dr Rutledge mentions social class and Dr Phillips and colleagues mention a high turnover of patients as well as unemployment and social disadvantage.

The underprivileged area score is a measure based on general practitioners' experience of factors such as these which increase their workload or the pressure on their services and has been shown to fit in well with the perceptions of general practitioners nationally.[1] The score has been accepted by the Underprivileged Area Sub-Committee of the General Medical Services Committee and by the annual conference of local medical committees.

In view of the low workload which Drs Fry and Dillane report in their paper and the high workload which your correspondents mention in connection with social factors, I thought it would be useful to look up the family practitioner committee area in which Drs Fry and Dillane practice and I find that they practice in an area with one of the lowest scores; in fact, of the 98 family practitioner committee areas in England and Wales, Bromley ranks 96.

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Reference

1. Jarman B. Underprivileged areas: validation and distribution of scores. *Br Med J* 1984; **289:** 1587-1592.

General practitioners and alternative medicine

Sir,

Ms Anderson and Dr Anderson (February *Journal,* p.52) set out to 'ascertain the beliefs of a sample of general practitioners about alternative medicine', yet their dismissal of the British Medical Association's report on alternative medicine[1] as 'unhelpful' and their uncritical quoting of the Prince of Wales's views on alternative medicine betray their own bias and belief. The authors first establish that there is great interest in alternative medicine among general practitioners, which, in turn, is used as a justification for providing training in alternative medicine.

The Andersons state that 42% of general practitioners in Oxfordshire 'would like training or further training in alternative medicine'. Unfortunately, the specific therapies were identified by the general practitioners and included manipulation, hypnosis, psychotherapy, relaxation and massage. These procedures are not alternative. As the BMA report[1] pointed out, manipulation is a part of orthodox therapy and 'one of the range of useful treatments for pain arising from spinal disorders'; hypnosis was accepted as beneficial to certain patients; and psychotherapy, relaxation and massage were not even discussed as they have nothing to do with alternative medicine.

If we read beyond the abstract of the paper it becomes clear that alternative medicine is practised by very few Oxfordshire practitioners. Out of the 222 doctors who responded only six used acupuncture and two homoeopathy.

The Andersons provide no evidence that those who wished to practice homoeopathy or acupuncture encountered obstacles in finding teachers. In Ireland, courses in acupuncture for general practitioners have been regularly advertised in the local medical periodicals. The December 1986 issue of *The Practitioner* is devoted to homoeopathy, acupuncture, osteopathy and clinical ecology; all the articles provide ample in-