LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

Health education: using a video in general practice

Sir,

In view of the importance of health education in general practice a study was designed to test the effectiveness of showing an educational video recording in a general practice waiting room. The study focused on preventive health behaviour linked to coronary heart disease, such as asking to have blood pressure measured during a consultation, or showing an active interest in pursuing a healthy lifestyle. Since the United Kingdom has one of the highest death rates in the world from heart disease,[1] it is important to find ways of encouraging preventive health behaviour.

One hundred and fifty seven consecutive patients attending one general practice were divided into three groups — the first group (n = 54) did not see the video, the second group (n = 53) saw the video in the waiting room and the third group (n = 50) saw it under semi-supervised conditions in a small room with no distractions. The age range of the sample was 14–81 years. Only seven patients asked questions about heart disease during their subsequent consultation but six were from the group who saw the video in the waiting room and one had seen it under supervision. More patients who had seen the video asked to have their blood pressure recorded than those who had not (33.0% versus 18.5%). When the response of the 'high risk' group of men aged 35–65 years was examined it was found that many more men who had seen the video asked to have their blood pressure measured than those who had not (9/13, 69.2% versus 2/12, 16.7%). It seemed that for this group the video acted as a cue to action. Although there were only a small number of participants in this particular age range, the results of this study suggest that it is useful to use audio-visual materials in such a setting, focusing on particular groups who may benefit from health education material. The effect of such exposure may not be immediate, however, and there may be difficulties in measuring the precise response.

Further investigations into the use of video recording in the waiting room would be worthwhile, allowing conclusions to be drawn about the effectiveness of such materials. Questions may be raised about the groups which are targetted for such education, the type of information presented, and the manner of presentation. In addition the logistical aspects of setting up a video machine in the waiting room would need further consideration.

Although conveying knowledge is important, Bracken and colleagues[2] caution 'Unless the knowledge gained ... is translated by patients into appropriate modifications of lifestyle the programmes will have no impact upon subsequent morbidity.' It is hoped that this study will further open the area for discussion, and for more experimental investigations.

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References

1. Fowler N. Look at your heart. *Health Trends* 1987; **19:** 2.
2. Bracken MB, Bracken M, Landry AB. Patient education by videotape after myocardial infarction: an empirical evaluation. *Arch Phys Med Rehabil* 1977; **58:** 213-219.

Appointing counsellors in general practice

Sir,

I read Colin Newman's letter (September *Journal,* p.388) about the appointment of psychologists and counsellors within general practices with great interest. His explanatin of the significance of the new term 'chartered psychologist' was instructive and the distinction he drew between psychologists and counsellors exemplary. What I fear may lead to misunderstanding is his final recommendation: 'if a general practice wishes to appoint a counselling psychologist who has specific competence in the psychology of counselling again we recommend that only chartered psychologists with appropriate experience of counselling should be appointed.' This statement, particularly if it is read in isolation from the very fine distinctions drawn in the earlier part of the paragraph, may all too easily be taken to mean that only counsellors who are also chartered psychologists, should be appointed as counsellors in general practice.

Counsellors do indeed come from a wide variety of backgrounds, but the British Association for Counselling, as the representative body in this country for counsellors, has drawn up precise guidelines about appropriate training in counselling, has a formal recognition scheme for counsellor training courses and an accreditation scheme for individual counsellors. Using the standards set out in these schemes as guidelines, general practitioners should not needlessly restrict their search for competent counsellors to members of the British Psychological Society, or indeed to members of the British Association for Counselling, though they would be wise to enquire what code of ethics and practice any counsellor adheres to, as well as what training in counselling they have undertaken. The British Association for Counselling code of ethics and practice for counsellors states plainly 'It is an indication of the competence of counsellors when they recognize their inability to counsel a client and make appropriate referrals' and, 'The association has a complaints procedure which can lead to expulsion of members for breaches of its codes of ethics and practice'. Both clauses echo the concerns of the British Psychological Society in maintaining high professional standards in a newly developed field of work.

Any readers wanting more information about counselling in general practice should await the forthcoming publication of the information folder *Counselling in general practice,* commissioned by the Royal College of General Practitioners and written by members of the counselling in medical settings division of the British Association for Counselling. It gives a comprehensive and authoritative description of what counselling involves and how it can fit into the pattern of primary health care.

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