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-

formation for anyone interested in further training.

The Andersons ask for 'adequate and recognized training' but what harm can ensue from homoeopathy without 'recognized' training? It is not inadequate training in homoeopathy and such like which makes a doctor dangerous; the danger stems from his inadequate training in the processes of rational thought.

It is not completely true to say that 'few concerted or systematic scientific trials have been carried out' in the area of alternative medicine. In the case of acupuncture, numerous trials have been published in reputable journals, showing that acupuncture does not differ from placebo.[2] Detailed critiques of acupuncture and homoeopathy[3] have been ignored by the advocates and remain unanswered. It is regrettable that the BMA report[1] accepted unsubstantiated claims for the role of acupuncture in pain and allowed themselves to be misled by partisan evidence.

We agree with the Andersons that 'we have a duty to the public to assess the benefits and harms of alternative practices'. This should be done before providing further training. We have the same duty to medical students and postgraduates, and we strongly recommend that critical appraisal of alternative medicine becomes a part of undergraduate teaching. The interest of some doctors in alternative medicine, however, is not a sufficient reason for teaching them how to earn money by employing it. For example, the present heightened interest in faith healing, including trials of faith healing in men with cataract and in horses with intestinal parasites, in British academic institutions, is surely not a sufficient reason for introducing courses in faith healing in medical schools.

As much of orthodox medicine is still magic, it is not easy to separate the husk of the absurd from the rational nucleus. The question is not how to accommodate more magic in medicine but how to get rid of it.

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2. Skrabanek P. Acupuncture: past, present, and future. In: Stalker D, Glymour C (eds). *Examining holistic medicine.* Buffalo, NY: Prometheus Books, 1985.
3. Simpson JY. *Homoeopathy: its tenets and tendencies.* 3rd edition. Edinburgh: Sutherland and Knox, 1853.

The College and its Council

Sir,

The debate over 'What sort of College?' has continued for more than a decade but as yet no conclusion has been reached. As a College, we are pledged to help individual general practitioners to improve the standard of care they give to patients. We have produced important policy statements and recommendations about standards of care but cannot claim that these have been implemented by every member. There is a credibility gap between what we say is possible and what happens in our practices. (We sometimes give the impression of being a self-perpetuating oligarchy.)

Style. A small handful of people cannot and should not be seen to run the College. All the members of the General Purposes Committee and of Council must be actively involved in decision making. This will require more people to devote more time to the College but is likely to produce decisions which are not only correct and appropriate, but which are based on the practical problems faced by all general practitioners.

Structure. Having decided what the College seeks from its central organization in terms of policies and leadership, then the appropriate individuals for certain jobs must be more democratically selected than they are at the moment. Faculty representatives need to discuss the posts to be filled and the potential candidates with their faculties several months in advance. Council will then be in good position to democratically elect doctors to the important positions in the College.

Central thought versus peripheral action. The main aim of the College relates to the individual general practitioner's care of patients. The Communications Division through its information folders and the Education Division through the Annual Symposium are two ways in which the College seeks to help doctors. These successful initiatives are a guide for the College's future development. Faculties have shown in their work on the CASE programme and in preparation for the Annual Symposium 1986, that they can also produce high quality educational material. Council must encourage and trust College members and faculties to be active in practical educational projects.

The problems of the past year have been traumatic both for individuals and the College, but change is now likely to occur. However, the nature of any changes and their manner of introduction, need to be agreed and accepted by the whole membership. Without this agreement changes in structure are unlikely to produce the desired changes in behaviour.

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The Diploma in Geriatric Medicine

Sir,

As the only person as yet who has examined both for the Diploma of Geriatric Medicine and the MRCGP I should like to make a few comparative points.

The main difference between these examinations is the clinical orientation. The DGM is based, of course, on papers testing knowledge base and ideation, but the long and short cases presented to the candidate enable examiners to observe clinical, attitudinal and communicative techniques at the time. The examiners are consultants and specially chosen general practitioners working in pairs. The candidate is allowed half an hour with the long case, and then reports to the examiners who conduct an interview on the findings, the elicitation of physical signs, and the solution of problems. Other examiners take the candidate through three short cases, for example tardive dyskinesia or speech defects like fluent dysphasia.

I always found it difficult to estimate a doctor's real quality from the MRCGP oral examination, for even if his/her attitude seemed good I often wondered whether a doctor would always do what he told us. A good examiner is not left completely in the dark, however. What the DGM indicates is that after a few years in a medical service in which the average consultation time is six minutes clinical skills become eroded. For this reason alone, trainees have the advantage of being closer to hospital medicine but this is something I have recently deplored as an indoctrination from which the reconceptualization needed for general practice is almost impossible.

The DGM is a most important test at a time when the population is ageing and diseases of external origin have largely disappeared.

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