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Patient self management of asthma

Sir,
Asthmatic patients need to know when to adjust their medication and how to recognize when their asthma is going out of control. The difficulty is how to convey this information clearly. Beasley and colleagues¹ developed a simple self management plan, using daily peak flow readings, for asthmatics and found that patients 'improved significantly in all objective and subjective measures of asthma severity'.

They introduced the concept of potential normal peak flow values. These values are derived from the highest consistent peak flow values achieved or the highest predicted value, whichever is the greater. Patients are given clear action guidelines, based upon a drop in peak flow from the potential normal value — 70% and 50% of the potential normal value are the two action levels for patients.

We have devised a method for doctors which simplifies the advice that they may give to patients.

1. Calculate the potential normal peak flow value from the highest consistent earlier documented peak flow rates, or the highest predicted value as described by Beasley and colleagues.¹
2. Look at the chart (Table 1), to ascertain the corresponding 70% and 50% levels for this potential normal value.
3. Mark the patient's peak flow chart with a line at each of these levels (Figure 1).

Table 1. Peak flow action level calculator. Determine the patients potential normal peak flow level and then read off the action levels from left to right.

Predicted (or best)	Peak flow values (l min ⁻¹)	
	70%	50%
650	455	325
·	·	·
510	357	255
500	350	250
490	343	245
·	·	·
50	35	25

The patient can then see clearly, by keeping a daily record, when their asthma

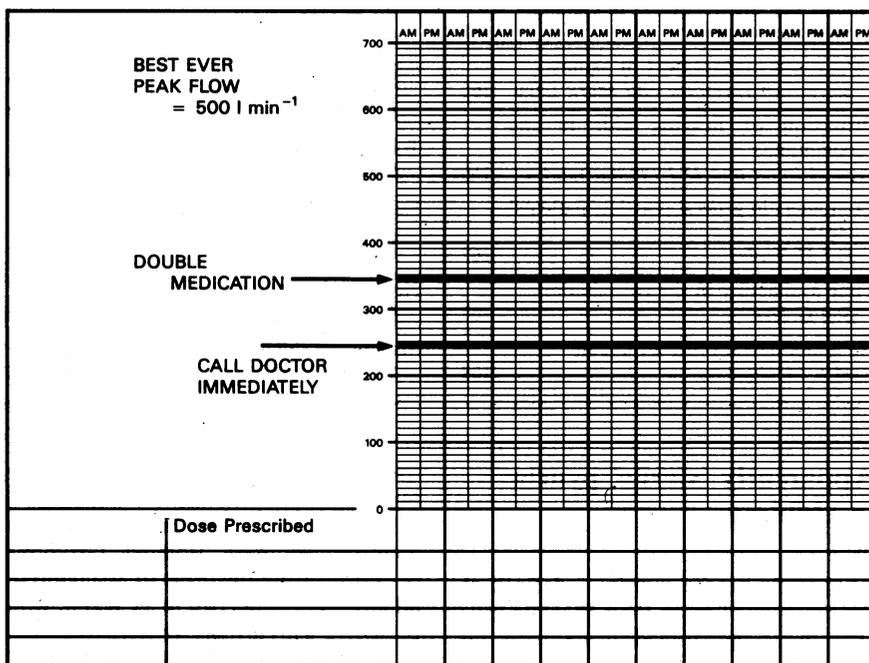


Figure 1. A patient's peak flow chart marked with 70% and 50% levels.

is going out of control. If the peak flow rates drop below the 70% line then patients are advised to double their medication and continue at this dose until the previous potential normal values are reached. They should count the number of days it took to reach these values and then continue at the double dose for the same number of days. If the peak flow rates drop below the 50% line patients are advised to take a dose of oral steroids, double their medication and contact the doctor urgently if they are no better. If they improve on double medication they should continue as above. The steroids should be continued until the potential normal value is reached and then half the daily dose taken for the same number of days.

This advice can be provided in a written form or adapted by the general practitioner or practice nurse to suit the understanding of individual patients. Thus, the excellent research by Beasley and colleagues¹ can be practically applied for the benefit of patients.

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Provision of hearing aids in the community

Sir,
Decentralization of the dispensing of hearing aids from hospital based specialist units to general practice based community sites is suggested by the Royal National Institution for the Deaf, because some hospital based services can mean lengthy delays.¹ A survey in 1984 showed that the average waiting time for an ear, nose and throat (ENT) outpatient appointment in the UK was 16 weeks, with regional variation ranging from one to 132 weeks.² With an estimated 3.9 million adults with hearing impairment which might be helped by an aid, and an ageing population, this demand will inevitably increase.

General practitioners' views on the proposals of the Royal National Institution for the Deaf need to be established before a community based service for the provision of hearing aids is set up. We therefore conducted a survey among general practitioners in north Kent. Questionnaires were sent to 210 general practitioners asking for their views on hearing aid dispensing by general practitioners in the community, for details of their previous ENT training and whether they would be willing to undertake further ENT training with a view to dispensing hearing aids in the community. One hundred and sixty replies were received (76% response rate).

Eighty five per cent of respondents were in favour of community based hearing aid dispensing, 19% had previous ENT training and 41% were willing to undertake further training. Among the 30 doctors who had previous ENT training three doctors had had 12 months training, eight doctors six months, seven doctors three months and 12 less than three months.

There is thus strong support among general practitioners for the provision of hearing aids in the community and nearly half the respondents in this study would be willing to undergo further training. A trained general practitioner would be able to remove wax from the ear and differentiate the types of otitis media, and also detect patients with asymmetrical hearing loss.

One in five patients seen in ENT clinics are patients who were referred for hearing aids;³ decentralization of this service would save valuable time in busy ENT clinics. This faster and more accessible service would thus benefit the consumer.

The provision of hearing aids in the community will only require the involvement of a small number of interested and adequately trained general practitioners in any one district with the support of community audiology technicians. Vocational training in otolaryngology should be oriented towards practical aspects of the provision of hearing aids with the aim to create a hearing aid list analogous to the obstetrics list with financial incentives being offered to the practitioner.

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Computers in general practice: patients' views

Sir,
There has been a considerable amount of talk about the need to computerize general practice. Family practitioner committees are mainly computerized, and hospitals and laboratories are also moving in this direction. Much has been heard from the present government of their intention to have a computer on the desk of every

general practitioner in the near future. The intention is to allow easy access to waiting lists, family practitioner committees, and make reasonable and speedy audit more feasible.

At the present time only 32% of practices are computerized while according to VAMP another 33% have declared their intention to buy a computer in the next year.¹ It is possible that the future contract for general practitioners will encourage more practices to become fully computerized. Indeed it is difficult to see how practices without a computer will easily achieve targets and produce sensible audit.

One group of people have been largely left out in the debate about computers in general practice. Patients usually put up with whatever is done in practices as long as it is designed to be helpful and is not overtly threatening. A computer on the desk, however, could appear threatening. A study by Rethans and colleagues² suggests that patients are on the whole in favour of personal computers in the surgery. In a study by Potter³ in 1981 nearly 30% of patients thought that the presence of a computer might adversely influence the consultation and some patients even stated that they would leave the practice. Cruikshank⁴ in 1984 reported that over half of the responders thought that the presence of a computer in general practice would adversely affect the personal touch of the doctor, whereas Pringle and colleagues,⁵ found that 17% of patients were opposed to computerization largely on the grounds of possible loss of confidentiality.

A recent simple questionnaire study in general practice looked at whether patients' attitudes had changed in this country as a whole, now that computers are more widely used and now that more patients have some experience of computers in medicine and, frequently, at home. Special note was taken of patients' attitudes towards the desk top computer, and an attempt was made to discover what their fears were.

A total of 1090 replies were received from patients of several members of the Janssen research group. The results showed that 93% considered that computer generated letters and recall were advantageous, while 74% thought that standards of medical care would improve. Eighty four per cent had no objections to the storage of medical records on computer although several raised the question of confidentiality.

Regarding the use of a computer on the doctor's desk, 84% of patients had no objection to the use by the doctor to check records, but only 76% were happy to have

the computer used as part of the consultation.

This simple study has shown that while the majority of patients do not mind the use of computers in practices and are not threatened by them given certain safeguards, there are still a significant minority (one in four) who are unhappy about the use of a computer during the consultation. To gain the full support of our patients it appears that there is still considerable room for further education. Perhaps the most important message is from one patient's comment that computers should complement but not replace the general practitioner.

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Time availability in the consultation

Sir,
I was most interested in the study of the effect of time availability on the consultation by Ridsdale and colleagues (December *Journal*, p.329). I became interested in the relationship between consultation length and content when looking at my own performance in order to determine a suitable booking interval. The dissolution of my partnership meant that my list size fell from 1650 (that is 3300 between two doctors) to 950 and as a result I was able to increase my appointment booking interval from 8.0 minutes to 10.0 minutes. I have carried out a study (unpublished) measuring durations and various aspects of the consultation before and after this decrease in list size and increase in booking interval.

The mean consultation duration rose from 9.0 to 10.2 minutes, with in both cases a range of 1-40 minutes.

Before the changes in list size and booking interval I showed that as the patient's consultation length increased there was a rise in: prescribing rate, number of problems dealt with, referral rate, amount of preventive activity, proportion of new pro-