

group, all of whom should have been vaccinated under the school vaccination programme, 19.1% stated they had not been vaccinated and 23.3% could not remember being vaccinated. The school was the main source of education concerning rubella in the younger age groups and television and radio most informative for the older females.

In conclusion we felt that, although the overall rates of non-immunity in our study were low, the serious effects of rubella infection in pregnancy warrant general practitioners offering routine immune status testing to patients. This would have to be part of a coordinated practice policy. A family planning consultation may be the optimum time to determine the immune status. None of the 237 patients studied had attended specifically to get their rubella immunity checked.

Although awareness of the dangers of rubella infection are high, almost a quarter of patients in the 14–20 year age group did not know if they had been immunized or not. We feel that a history of rubella infection or vaccination should be recorded as part of the basic medical data base on any female patient in the child-bearing years.

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#### References

1. Rowlands S, Bethel RGH. Rubella vaccination: screening all women at risk. *Br Med J* 1981; **238**: 829-831.
2. Rose AJ, Mole KF. Rubella immunisation and contraception — a case for re-examining the policy of the Department of Health and Social Security. *J R Coll Gen Pract* 1976; **26**: 817-821.

## Topical Fucidin

Sir,

In view of the persistent recommendation from some quarters that topical sodium fusidate (Fucidin, Leo) shall enjoy wider use, we wish to report a case of relevance.

A 63-year-old diabetic woman with chronic renal failure presented to her general practitioner with excoriated lesions of both shins and the back of her neck as a result of uraemic pruritus. Topical Fucidin was prescribed and used on the affected areas. Ten days later the patient presented to the hospital with dehydration, persistence of the excoriated areas with surrounding erythema on the legs and a pustule on the neck. Swabs were taken from the inflamed sites and the pustule. Blood cultures which were taken at the same time grew no organism and she remained apyrexial.

*Staphylococcus aureus* of the same phage type (95) was isolated from all swabs taken from the different wounds and it was found to be resistant to fusidic acid (minimum inhibitory concentration 4 g<sup>-1</sup>) but sensitive to penicillin. Attempts to demonstrate plasmid mediated resistance to fusidic acid using the technique of Lacey and colleagues<sup>1</sup> were unsuccessful, hence, we presume that this was chromosomally coded.

Fusidic acid was first introduced around 1961 when clinical *S. aureus* isolates were almost universally sensitive to the drug. However, resistance could have been demonstrated *in vitro* in approximately 1/10<sup>8</sup> colonies even at that early time. This resistance arose by chromosomal mutation and acted by altering the effect of the drug on the cell ribosome. Chromosomally mediated resistant strains have been shown to grow more slowly than sensitive ones<sup>2</sup> and colonies may revert to fusidic acid sensitivity if the selective pressure is withdrawn. Plasmid mediated *S. aureus* resistance, which has been particularly demonstrated in association with dermatology units does not seem to confer slow growth or disadvantage on the bacterium and it has been shown to remain pathogenic and infective.<sup>3</sup>

It has been suggested that resistant strains of the type found on this lady's lesions are much less pathogenic and ecologically at a disadvantage compared with coexisting fusidic acid sensitive strains. This case demonstrates that these bacteria can remain the sole causative agent in pathogenic lesions and can remain infective. Fusidic acid resistant *S. aureus* were recently found to be carried by less than 1% of general practice patients who had received topical fusidic acid and this has been used to alleviate the fears that its use may build up resistance in the community. We would use this case to show that the resistant organisms so selected by the use of topical fusidic acid can remain pathogenic and infective.

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#### References

1. Lacey RW. Genetic basis, epidemiology and future significance of antibiotic resistance in *Staphylococcus aureus*. *J Clin Path* 1973; **26**: 899-913.
2. Chopra I. Mechanisms of resistance to fusidic acid in *Staphylococcus aureus*. *J Gen Micro* 1976; **96**: 229-238.
3. Ayliffe GAJ, Green W, Livingston R, Lowbury ELL. Antibiotic resistant *Staphylococcus aureus* in dermatology and burn wards. *J Clin Path* 1977; **30**: 40-44.

## Data Protection Act

Sir,

I am glad to see that you have published a summary guide to the Data Protection Act for general practitioners (December *Journal*, pp. 591-593). I wish to encourage all general practitioners who hold computerized data to do the following when registering as data users:

1. To register research and statistical analysis as one purpose for which data are held.
2. To register research workers as individuals to whom data may be disclosed.

Needless to say, the inclusion of these registration particulars will not commit general practitioners to collaboration with research workers such as myself but it will make it possible for them to collaborate should they wish to do so.

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## How do doctors react to being videotaped?

Sir,

As a newly appointed course organizer I was keen to explore the most useful and least stressful way of looking at the consultation. My own experience as a trainee had led me to believe that viewing role-played consultations (using other trainees as patients) was better than not seeing oneself at all, but often unrealistic. An article in *Trainee*<sup>1</sup> drew my attention to how unpleasant one trainee had found this experience, and stimulated me to assess the acceptability to trainees of something to which they are increasingly being subjected — videotaping and viewing their consultations, either real or role-played.

Davis and colleagues showed that although more than half of a group of 41 students, trainees and experienced doctors were apprehensive before being filmed with a patient in a surgery, only seven remained apprehensive afterwards.<sup>2</sup> I wanted to see if this degree of acceptability was true in other centres.

By means of a postal questionnaire I compared the reactions of groups of general practitioner trainees in the Oxford region and West of Scotland who had undergone simulated consultations with role-played patients. In addition to this, those in the Oxford group had all been videotaped with real patients in their own surgery and their reactions to this ex-