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 childbearing years.

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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 gl^{-1}) but sensitive to penicillin. Attempts to demonstrate plasmid mediated resistance to fusidic acid using the technique of Lacey and colleagues[1] 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 $1/10^8$ 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[2] 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.[3]

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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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*[1] 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.[2] 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-

Table 1. Reactions of trainees to the videotaping and viewing of their consultations.

Score[a]	Simulated consultations				Real consultations (Oxford group only)	
	Being recorded		Viewing recorded		Being recorded	Viewing recording
	Glasgow	Oxford	Glasgow	Oxford		
1	2	0	2	0	0	1
2	9	12	5	2	4	2
3	15	12	9	16	15	10
4	10	6	16	12	12	18
5	3	2	6	2	1	1
Total	39	32	38	32	32	32
Mean	3.08	2.94	3.50	3.44	3.31	3.50

[a] 1 = very unpleasant, 2 = unpleasant, 3 = neutral, 4 = pleasant, 5 = very enjoyable.

perience were also determined. The results obtained are shown in Table 1.

Even in supportive and carefully controlled situations, approximately one third of the trainees involved found it unpleasant to be filmed in a role-played consultation in unfamiliar surroundings. However, only four out of 32 trainees in the Oxford group who were filmed with real patients in their own surgeries found this experience to be unpleasant. The same group also found it more pleasant to view these recordings than their role-played consultations.

All the trainees involved were inexperienced at being filmed, and it would be expected that the number continuing to find this experience unpleasant would be smaller. However, it must be appreciated that no matter how often they are filmed, some people continue to find this experience unpleasant.

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Quality control in the National Health Service

Sir,

The reason why quality assessment and quality control should be applied to the National Health Service (NHS) is that the quality of the service would be substantially improved. Moreover, improved efficiency and better utilization of resources will result.

Some assessment and control of quality already exists in the training and promotion of doctors. Continual scrutiny, accompanied by criticism and advice is *de rigueur* for junior doctors. Why does this scrutiny suddenly cease upon appointment as a general practitioner or consultant? Both groups make errors and good and bad practice do co-exist. However, at present the two jobs do not receive even occasional outside assessment. Quality checks are mandatory for aeroplane pilots, and commodities such as food and cars, yet NHS doctors, concerned with the physical and mental wellbeing, life and death of humans and financed by the tax-paying public, have no quality assessment or control beyond their junior ranks.

Doctors treat medical mistakes with silence and patients who know or suspect that they have been the victim of a mistake usually see no point, or are too upset or timid, to enlighten the medical establishment. Thus both doctors and patients tend to suppress errors. This is no way to pursue excellence and errors and misjudgements highlighted by a third party are educative — this is a major component of the training of students and junior doctors.

Once the notion of quality assessment and quality control has been recognized, the next step is how best it may be implemented. In the USA quality in medicine is often assessed by a lawyer. However, the best equipped persons to assess doctors are doctors in a group drawn from a variety of disciplines. It has been suggested that these doctors should make assessments under four headings — clinical competence, accessibility, ability to communicate and professional values.[1]

It is hard to dispute that such an assessment would be a forward step. However, quality assessment in medicine is new and for many a threatening concept. By pursuing it under the above headings it might prove prone to accusations of subjectivity and this would set back the successful implementation of a system of quality assessment.

A better starting point would be the identification of errors of direction and judgement. In general practice examples of such errors are found in referral letters to hospital — the man referred to a surgeon who removes a rectal carcinoma; six months previously the man had presented to his general practitioner with rectal bleeding and was treated for resumed piles. Whether such errors are one-off or indicative or overall poor practice, they should not pass without remark. It is precisely because bad practice may be uncovered that these errors should come under scrutiny. Hospital errors, perhaps more difficult to identify, should for the same reason be sought. Further, consultants should be called upon to account for the content and duration of bed occupancy and waiting lists.

Quality assessment, rather than more money, is the immediate need of the NHS. The question of how to exact quality control may be left in obeyance for the time being. Quality assessment can be expected to raise overall standards; this desirable effect is, in itself, quality control.

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Preventive care of pre-school children

Sir,

I understand that both the General Medical Services Committee of the British Medical Association and the RCGP wish to encourage the preventive care of pre-school children within the setting of general practice and that training practices should encourage young doctors to develop the skills for this work.

I have been a part-time trainee in general practice since June 1984 and feel that six months as a senior house officer in a hospital paediatric department is insufficient training for paediatric medicine. In July 1984 I answered an advertisement for a course on developmental examination at the Institute of Child Health. I have now been told that I have a place on the 10-day course that begins on 29 January 1986. However, my pleasure at receiving this long-awaited news was shortlived as it was followed by an invoice for £240. I am asking my family practitioner committee to pay this course fee but