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## Vaginal speculum examination

Sir,

For several years I have been using a technique to make passing a vaginal speculum easier for patient and doctor. I have yet to find another doctor or nurse who uses this technique. It may be of help and interest to readers.

When explaining to the woman what I am going to do, I tell her that I will ask her to squeeze 'down below' around the end of the speculum (suitably warmed and lubricated) as soon as I have introduced it gently into the entrance of the vagina. Immediately after the squeeze, the vaginal muscles relax and the speculum slips in easily. When the speculum meets any resistance, I ask again for a squeeze and as many more as needed to pass the speculum to the required position in the vagina. Almost all the women who have done this have been relieved and say how much easier this technique is compared with 'the usual discomfort'.

In an intrusive procedure like passing a vaginal speculum, any method to reduce unpleasantness and therefore enhance the doctor/nurse-patient relationship is useful.

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***Tinea capitis*: a novel mode of transmission**

Sir,

We have become aware of a new means of spread of *tinea capitis* among young and teenage boys.

A five-year-old boy presented with multiple areas of alopecia over the back of the head, within the shaved area of his hairstyle. Culture of plucked broken hairs from the affected area grew *Microsporum canis*, and the infection cleared following a six week course of oral griseofulvin.

We are seeing an increasing number of children with *tinea capitis* associated with the current trend for shaved hairstyles. It appears that the same razor may be used for many children (particularly, if the hair-styling is done by amateurs). Awareness

of the need for adequate disinfection of such razors is imperative, in order to prevent an epidemic of *tinea capitis* among the fashion conscious.

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## Asthma and computer games

Sir,

There have been reports in the media of certain computer games triggering epileptic seizures and some games even carry a health warning to this effect. However, I report a case of a 10-year-old girl who developed an acute asthma attack while engaged in a computer battle game.

The girl suffered from mild asthma with infrequent episodes of wheeze on maintenance therapy of inhaled beclomethasone dipropionate 100 µg twice daily. She had been well for over 18 months with no clinically significant wheezing. On this occasion she had been staying at a friend's house for two days. She was playing on a computer game for 20 minutes when she had to stop because of acute breathlessness and wheezing. She was unable to speak and required her salbutamol inhaler. She was fully recovered after two hours but felt anxious about re-engaging in the computer game. There were no other factors to account for this exacerbation of her asthma.

The effects of intense concentration and excitement induced by sophisticated and challenging computer software is analogous to the fight or flight response. The triggering of an asthma attack may be an inevitable consequence in certain sensitive individuals who may be advised to take prophylactic bronchodilator therapy before playing certain computer games.

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## Identifying asthmatic patients

Sir,

In the paper by Sue Ross and colleagues (June *Journal*, p.236) I note that at no time was the consent of the patients concerned sought before their names and addresses were passed on to a third party.

The general practitioners' consent is immaterial. The Pharmacy Practice Division in Edinburgh would appear to be in breach of its duty of confidentiality as well as its duty under the data protection act as the data was stored on computer.

The general practitioners concerned would also seem to be in breach of their duty of confidentiality by passing on information about clearly identified patients without their consent.

These views were confirmed by the Medical Protection Society when, as a member of an ethics committee, I was presented with a similar problem.

J E SCRIVEN

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Sir,

The letter written by Dr Scriven in response to our recent paper contains some inaccuracies, particularly with reference to the Pharmacy Practice Division of the Common Services Agency of the National Health Service in Scotland. The division has a strict code of confidentiality, to which it adheres rigorously. Prior to the release of any data, researchers must provide full details of any study they are undertaking. In our study, we used GP10 forms to identify possible asthmatic patients in two health board areas of Scotland. The Pharmacy Practice Division gave us access to prescription forms (GP10 forms) only when the general practitioner had given written permission for us to access their forms for the purpose of the study. The Pharmacy Practice Division database contains no patient information, although it does contain data identifying individual prescriptions. These data may be used for medical research, in accordance with the data protection act.

Once possible asthma patients had been identified, we wrote to each general practitioner in the study with the list of names and addresses, asking the general practitioners to verify that the patients had asthma, were within the desired age range and had not attended an outpatient clinic for asthma in the past 12 months. Once the general practitioner agreed that we could do so, we sent each patient a questionnaire about their asthma. Several general practitioners who thought it necessary contacted each patient before returning the verified list of names to us.

After the general practitioner had given consent for us to contact the patients, the patients could give their own consent (or not) to the study by replying to the questionnaire. When contacting patients, we clearly explained how we had obtained

their name and address, and the purpose of the study.

While we appreciate Dr Scriven's concerns about confidentiality, our research was aimed at developing and improving patient care by investigating integrated (or shared) care for asthma patients. Such developments must be properly evaluated, and the cooperation of general practitioners and patients is required in these investigations.

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## Response rates in general practice studies

Sir,  
Baker has recently noted that 'There is a depressing reduction in the proportion of general practices taking part in research' and suggests that increased pressure of work and changing attitudes among general practitioners towards research may explain this trend (letter, *July Journal*, p.307). There are a number of pertinent questions that should be raised by those of us working in university departments of general practice in an attempt to explain low response rates in general practice studies.

First, when requiring their participation do we fully consider general practitioners' work commitment? Bowling and colleagues have noted a reluctance by general practitioners to answer questionnaires because of the volume they receive.<sup>1</sup> Surveys carried out during the past five years may have experienced low response rates because of the new contractual changes that have occurred in general practice. These changes have increased general practitioners' workload<sup>2</sup> and have had effects upon their stress levels, job satisfaction and mental health.<sup>3</sup> There is also evidence that there is resentment by service general practitioners, the 'miners', towards their academic counterparts, the 'geologists', and this may limit their willingness to participate.<sup>4-7</sup>

Secondly, are our studies always adequately funded? Response rates to mailed questionnaires are dependent upon the level of funding available. Low budget studies are least likely to follow up non-respondents and therefore cannot expect adequate response rates.<sup>8</sup>

Thirdly, can we assume that all general practitioners want to participate in our

research? Cockburn and colleagues found that general practitioners may be opposed to the methods used, hostile to or uninterested in research or may be reluctant to participate following discussions with practice partners.<sup>9</sup> They found that there were no significant differences in practice size, general practitioners' sex and number of postgraduate qualifications between respondents and non-respondents, but reported a non-significant trend whereby response rates decreased as age and general practitioner experience increased. Subjects will have the motivation to respond only if they are involved in the subject matter of the survey<sup>10</sup> and general practitioners will not complete questionnaires if they disagree or dislike the topic being investigated.<sup>11</sup>

Fourthly, is our work perceived as a threat by general practitioners? While carrying out a quality of care study, Borgiel and colleagues realized that general practitioners were highly individualistic and were resentful of any interference in their activities.<sup>12</sup> They found that the best method of approach was to encourage personal contacts between the recruiters and the general practitioners. Cartwright and colleagues explored the reasons why a study that intended to analyse doctor-patient relationships attracted a response rate of only 18%.<sup>13</sup> They concluded that the proposed study encroached on the confidential nature of these relationships and was perceived by general practitioners as being threatening and was also seen as a potential disruption to the work of the practice.

Lastly, is the information about the study we give to general practitioners enough for them to be tempted to participate? Two research teams have suggested that raising the quality of the information given to general practitioners about proposed studies will not only improve response rates but also enhance the value of the data collected.<sup>14,15</sup>

Richard Baker is correct in saying that the reasons for the decrease in general practitioner participation in research should be analysed. Yet, it is also important to scrutinize the manner in which researchers seek their general practitioner participants.

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## Diabetic non-attenders

Sir,  
I read with interest the paper by Thomas and colleagues discussing the targeting of long-term non-attenders in general practice (*July Journal*, p.285) and, although agreeing that this is often a fruitless occupation, I feel some groups warrant such action.

Diabetes mellitus is a common condition, non-insulin dependent diabetes affecting up to one in 10 of us before we die.<sup>1</sup> Non-attendance rates in hospital diabetic clinics are high,<sup>2,3</sup> and the view of some hospital doctors that these patients can always be screened by their general practitioner may be misleading. In the same issue, Tunbridge and colleagues discussed an approach to auditing health care for non-insulin dependent diabetic patients and found that up to 14% of their diabetic patients were non-attenders at both hospital and general practice clinics (*July Journal*, p.291). In view of the high prevalence of complications in these patients (diabetic retinopathy is present in 38% of patients at diagnosis<sup>4</sup>) an aggressive approach by both hospital physicians and general practitioners must ensure that screening is carried out regularly. Non-attenders will always exist, especially with diseases such as diabetes where major lifestyle changes may be needed, but we