office (contract No RDO/18/31), Spanish Fondo de Investigacion Sanitaria (contract No 96/1798), the Wales office of research and development (contract No RC092), the Norwegian Research Council, the Council for Mental Health, the Department of Health and Social Welfare, and the Finnish Pensions Institute of Agricultural Entrepreneurs (contract No 0339).

Competing interests: None declared.

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(Accepted 15 August 2000)

Corrections and clarifications

Why journals should not publish articles funded by the tobacco industry

An electronic glitch affected the second article, by Gavin Yamey and Richard Smith, in this "For and Against" debate (28 October, pp 1074-6). This led to the reference numbers "disappearing" from the text. The complete article, including the references, is on the *BMJ*'s website at http://bmj.com/cgi/content/full/321/7268/1074

Updated New Zealand cardiovascular disease risk-benefit prediction guide

The legend above the risk prediction chart in this article by Rodney Jackson (11 March, pp 709-10) has a small error. In the right hand column ("Benefit 2") the final number needed to treat (at the $<2.5\%$ risk level) should be 120 [not 20]. We are sorry for the delay in alerting readers to this, although in the context, confusion was unlikely.

Disease impact number and population impact number: population perspectives to measures of risk and benefit

In this article by Richard F Heller and Annette J Dobson (14 October, pp 950-3) the job description and contact details for Professor Heller were wrong. He is professor of community medicine and clinical epidemiology, and the email address is mdehsdh2@fsl.scg.man.ac.uk

A doctor who changed my practice

Putting women in control

As a research registrar in obstetrics and gynaecology I was moonlighting and gaining extra experience doing family planning and youth clinics. Unlike most of my previous training I was expected to sit in and then be observed by a senior doctor. It was my great fortune to work with Fay Hutchinson, the medical director of the Brook Advisory Service, because she completely changed my approach to patients.

Many of the women coming for contraception, pregnancy testing, and abortion advice were young and had never had vaginal examinations or smears. They would be prepared on the couch as usual and then they were given a speculum and asked to "put that inside, please." As if it was the most natural thing in the world that a doctor would ask a woman to insert a speculum! And most did so with no fuss. I was so shocked. I was shocked by the strangeness of what I was seeing and the topsy-turvy relationship between doctor and patient.

This had been a stressful and complex procedure for me to learn as a medical student and senior house officer. Why did Fay do it? Because "women know best where their vaginas are—they put tampons, fingers, and penises in."

She was absolutely right. It's easy for women to insert a speculum, except for those who have come to expect the doctor to do it or who find "down there" distasteful. It is a particularly valuable technique for "difficult examinations" on women who are frightened or who have had bad experiences—for example, abuse or coercive sex—or painful gynaecological examinations. The women determine when they are ready, control the insertion, and cannot adduct their thighs or clamp their legs closed. They relax and it never hurts.

I have never had a problem since that day. Why had I never heard, seen, or even read about self insertion in my years of training? Because, Fay opined, "Male gynaecologists find it very hard to give up control." Having since resisted and yet reviewed many other aspects of my basic and routine practices I think she's wrong. All doctors find it hard to give up control, both sexes and all specialties. But sometimes it's beneficial for patients. Try it.

Susan Bewley *consultant obstetrician, London*

We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.