have a responsibility to ensure that benefits are paid in accordance with the law. The law requires medical certification and, as Dr Toon rightly points out, such certification for social security purposes is part of a general practitioner's terms and conditions of service.

I believe that a general practitioner's certificate, backed up where appropriate by the Benefits Agency's medical reference service, is a cost effective way of ensuring fair payments of sickness benefits. Where general practitioners have a conflict between the need to give an opinion and their doctor–patient relationship a confidential reference on form RM7 would lead to an examination by a disinterested doctor. Sadly this reference is not used as often as it might be: some general practitioners may prefer to continue to issue certificates in which they may have little faith in order to maintain the doctor–patient relationship.

I note that Dr Toon makes no reference to the statement to be completed by the patient's doctor (or other professional carer) on form DLA1 (part of the patient's claim for the new disability living allowance; a similar statement appears on form DS2 for attendance allowance). The statement requires no opinion from doctors completing it, nor are they expected to verify the patient's assessment of his or her disablement. It is simply a statement of the patient's main disabling condition. Doctors can, however, give any additional information they think may be important. It is then for the adjudication authorities to decide whether sufficient evidence is provided on the claim form. Where more information is required the adjudication officer can seek advice from the Benefits Agency medical staff, and/or other sources, including the patient's general practitioner in the form of a factual report (for which a fee is payable). Clearly the Department of Social Security has a responsibility to safeguard public funds and control machinery has been set up to guard against abuse of the system.

Doctors working for the Benefits Agency Medical Services would welcome 'clearly defined factual information', particularly on form RM2. Unfortunately, they are often expected to advise on such information as 'backache' or 'painful leg'. A properly completed form RM2 will frequently avoid the summoning of sick or disabled people for unnecessary examinations, while at the same time securing another opinion, from the reference service, on those who are fit to attend for examination and may be capable of some work.

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Postgraduate education

Sir,

On reading the paper by Murray and colleagues about a centrally organized scheme for postgraduate education (January *Journal*, p.19) I searched in vain for a suggestion that this scheme was better educationally. The study shows that the attendance at educational sessions of those general practitioners who join the scheme was better than those who do not subscribe. The authors go on to equate 'educational attainment' with number of sessions attended. However, education is a process whereby new skills are acquired together with knowledge and/or attitudes which improve your work.

The authors state that general practitioners must have adequate education to achieve what is required of them with respect to health promotion. I take a contrary view. Most general practitioners already know a lot more about health promotion than they have the time to apply.

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Undergraduate medical education

Sir,

Having read the editorial by Knox (December *Journal*, p.499) I would like to set the record straight. While Dick Scott was pioneering general practitioner teaching in Edinburgh, a group of four general practitioners in Manchester in 1956 started teaching medical students in Darbishire House, the new university health centre. This was long before Pat Byrne arrived as professor of general practice on the recommendation of Robert Platt. He arrived when three of the four original teachers retired and one of them, Dr Davie is now aged 90 years. Dick Scott, Stephen Taylor and John Stopford encouraged the general practitioners in their work at a time when doctors were afraid of taking students into their practice in case it interfered with the doctor–patient relationship and took too much time.

As the youngest of the four Manchester general practitioners I taught until 1986, and over a period of 30 years I hardly took a surgery without a pre- or post-graduate student being present.

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Outcome of the national health process

Sir,

Many people who have been patients of general practitioners or hospital doctors feel that they have been participants in, not a national health service, but a national health process. 'The doctor just ordered tests', 'didn't understand' or 'said just continue the tablets'. Such commonplace observations testify to the impersonal stamp impressed upon some patients. A typical explanation of this circumstance is that there are too few doctors for too many patients and so a process, rather than a service, is quicker and inevitable. In fact, the origin of the processing of patients lies less in their abundance and more in the deficiencies of medical training.

The alpha and omega of medical training is to instil the importance of chasing a named diagnosis and then to arrange treatment. Diagnosis is the doctor's reward, and treatment follows automatically. Medical ethos does not include the pertinaceous questioning of medical outcome. Although current training alludes to consideration of the whole patient, students or doctors fail their examinations for missing a clinical sign or diagnosis or citing inappropriate treatment. They do not fail for omitting to ask: Is the patient benefiting from medical intervention? Is the patient being made worse?

In medical emergencies little else but diagnosis and treatment is germane, and outcome, usually following hard upon treatment, is quickly evident. It is to emergencies, perhaps, that medical training is tailored. But much practice, especially general practice, does not comprise emergencies, and treatment and outcome are often connected not by minutes or hours but, in for example psychological or arthritic conditions, by days or weeks. Also, Pickering's law states that the more treatments there are for a condition the less certainty there is one of them will work. Uncertainty about the benefit of several prospective treatments demands that outcome be energetically sought, so that ineffective treatments be stopped or altered.

In some ways, the diagnosis and treatment are the easy part of medicine and the real challenge is to determine whether the