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

patient has benefited. Recent litigation surrounding anxiolytic drugs has caused a dramatic decrease in their long-term use (*Compendium of health statistics*, 1992). Had benefit unmistakably followed their use, nothing, one presumes, would have deflected doctors from prescribing them. Examination of these cases reveals prescribing as if by rote. How many other drugs are prescribed in this way? Which operations are performed by rote? It appears that having treated the patient by the book then medical vigilance can stop. For example, in 1985 over 2000 people over 65 years of age were admitted to hospital with gastrointestinal haemorrhage caused by non-steroidal anti-inflammatory drugs. Yet only 364 cards reporting adverse drug reactions to the Committee on the Safety of Medicines were returned.[1] The doctors' obligation ended, it would seem, with the first prescription.

Medical training must ensure that doctors have an objective mentality; that having 'gone by the book' does not obviate responsibility for continuing vigilance; that clinical trials, tradition and even fashion are not invariably oracular; and that the outcome of every medical intervention ranks in importance with diagnosis and treatment. When patients' views are habitually sought upon the benefit or otherwise of their treatment, and regard taken of their answer, they will not feel that they have a standard disease receiving treatment by rote. This new routine will, besides personalizing patients, exert a powerful downward effect on the incidence of iatrogenic disease.

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Practice nurses

Sir,

In 1968 the following advice was given to general practitioners when looking for a practice nurse '...a mature, flexible personality counted for more than higher qualifications, [and] that married women with a family at school were very suitable on the grounds of personal experience of problems in the home ...'[1] Have the attitudes of general practitioners changed in the last 25 years? Are practice nurses looked upon as the doctor's handmaiden or professionals with a different, but important, role in the primary health care team?

Some things have changed, in that there are more practice nurses,[2] who are particularly useful for carrying out the tasks of the new general practitioner contract.

Most practice nurses were pleased to rid themselves of nurse management that often seemed remote from the working situation. Yet to be the employee of another professional group may not be the answer. At first, the new role of practice nurses appears exciting and shows a flexibility suited to general practice but it could also be viewed as picking up the tasks that general practitioners feel are simple or menial chores, rather than considering whether these are part of nursing. Research in the United States of America shows nurses to be more effective in health eduction.[3,4] They are also more popular with patients, being perceived as being more approachable and easier to understand.[5]

Few practice nurses are involved with major practice decisions or have been invited to be nurse partners. If practice nurses were employed in a slightly different way, perhaps paid directly through the family health services authority then possibly general practitioners would regard them differently. Practice nurses could develop into family nurse practitioners. Nurses have a code of conduct which allows them to take responsibility for their own actions and which gives guidelines as to how this should be organized.

Are general practitioners flexible and democratic enough to work with practice nurses, accepting them as professionals of equal value? Sharing responsibility may even be to general practitioners' advantage.

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Bed backache

Sir,

By Young's modulus in physics the depression in a spring by a weight is proportional to the length of the spring. A spring mattress with a spring base will sag at pressure points even if the mattress is hard. To imitate the floor on which the human race has slept until recently this implies that a spring mattress should be convex to prevent this sag.

A sagging bed gives one backache in the morning that gets better as the day goes on. Improving the bed improves the pain, regardless of whether one is bedridden or takes exercise.

Bed backache is usually felt at the level of the iliac crests. This would correspond with overflexion of the lumbosacral joint. This can be demonstrated to patients by either the patient or doctor lying on the floor and a hand being pushed through under the lumbar spine. Backache can be relieved by rolling up a small sheet or big towel to make a 5 cm to 10 cm roll and pushing this across under the mattress at the bottom of the shoulder blade level or a little lower. Sleeping better is the sign that this is correct. Improvement is immediate though the back can be tender for some weeks.

Some beds can be bought with a hard middle which helps in this context. Sleeping on one's side may help.

Taller people usually slump in their seats, placing a strain on their lumbosacral joint. The seat of a chair should have a tilt backwards and should not, unlike many car seats, have a bump below the level of this joint.

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Audit in the 14th century

Sir,

In this time of cost awareness where audit and accountability are buzz words in the National Health Service readers may be interested in a quotation from the *Liber niger* of Edward IV, which was a collection of ordinances and regulations for the government of the royal household: 'the costes for all medycines belonge to the chamberlayne his audite in the jewellhouse'.[1] One wonders if the royal physician had an indicative prescribing amount in the 14th century. As an interest in history repeatedly reveals, there is nothing new.

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