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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