

Brumfitt and colleagues. In the limited space available suffice it to point out that in the first study the antibiotic data are clearly incomplete and some patients were seen only once a year by a urologist, with follow up data being sought by questionnaires sent to general practitioners.⁸ In the second study specimens were obtained from patients in Crewe and sent by post on dipslides and in boric acid to a laboratory in London.⁹ As no attempt was made to detect fastidious organisms it is unjustifiable to draw conclusions about the effect of antibiotics on the possible presence of such organisms.

In my experience attempts to eradicate lactobacilli from the urethra by giving antibiotics facilitate infection with resistant bowel organisms. The only approach to the problem that I have found to be successful is to withhold antibiotics and await the gradual restoration of a balanced urethral flora.¹ The earlier in the natural course of the condition that this approach is adopted the more likely it is to be successful. If these patients are treated repeatedly, and particularly if long courses of treatment are given, the likelihood of the recalcitrant establishment of lactobacilli, or other fastidious organisms such as *Gardnerella vaginalis*, in the tissues is greatly increased. For this reason our laboratory's reports of specimens from which lactobacilli are isolated carry a suggestion that antibiotics should be withheld.

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SIR,—The subtitle to Professor W R Brumfitt and colleagues' editorial on the "urethral syndrome" was "A rapid and accurate test for bacteriuria would improve its management."¹ Such a test, which combines symptoms, history, and data from analysis of urine by adding scores to produce a probability of bacteriuria, has been described² and has a sensitivity of 87% and a specificity of 74% for all women. Use of this B score (bayesian analysis score) test in the population of women studied would have resulted in immediate antibiotic treatment for 87% of patients with infected urine instead of 74% and a reduction by a third in the number of patients without infection given antibiotics.

The table gives the scores for women aged 15 to 49. The test is done by adding the "present" factor for items of data that are present in the patient and the "absent" factor for items that are absent. The final total corresponds to the odds of infection if it is positive or to the odds against infection if it is negative; zero indicates a 50-50 chance of infection. Scores of 2, 3, and 4 correspond to odds of 2 to 1, 3 to 1, and 4 to 1. For every increase of two in the total score above this the odds are doubled (that is, a score of 5 corresponds to odds of 6 to 1

B scores for predicting bacteriuria in women aged 15-49 according to whether item of data is present or absent

	Present	Absent
Symptom:		
Frequency	1	-3
Nocturia	2	-2
Dysuria	2	-2
Urgency	1	-1
Haematuria	3	0
Offensive smell of urine	2	0
Nausea	-2	0
History:		
Symptoms for ≤9 days	1	-3
Previous intravenous pyelography	2	0
Dipstick test result:		
Protein	3	-1
Blood	3	-3
Nitrite	11	-2

(3 doubled), 6 corresponds to odds of 8 to 1 (4 doubled), and so on. A cut off of zero (a 50% chance of infection) gives the sensitivity and specificity balance quoted above and works well in practice.

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- 1 Brumfitt W, Hamilton-Miller JMT, Gillespie WA. The mysterious "urethral syndrome." *BMJ* 1991;303:1-2. (6 July.)
- 2 Dobbs FF, Fleming DM. A simple scoring system for evaluating symptoms, history and urine dipstick testing in the diagnosis of urinary tract infection. *J R Coll Gen Pract* 1987;37:100-4.

SIR,—Professor W Brumfitt and colleagues comment that a rapid and accurate test for bacteriuria would improve the management of the "urethral syndrome."¹ In particular they suggest that such a test, giving a result within minutes, would reduce the unnecessary and undesirable prescription of antibiotics for this condition by general practitioners.

Although the ideal test does not exist, the detection of pyuria by low power microscopy of a drop of urine is a useful predictor of appreciable bacterial growth.² This examination takes seconds rather than minutes to perform. For practical purposes the absence of pyuria excludes important bacterial infection and the presence of pyuria, though not conclusive, usually indicates infection. Combined chemical tests are not quite as good as microscopy but are still useful in identifying urinary infection.^{2,3}

Routine examination of the urine of patients with frequency and dysuria before treatment is prescribed would go a long way towards achieving the improved management of the condition sought by Professor Brumfitt and his colleagues.

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- 1 Brumfitt W, Hamilton-Miller JMT, Gillespie WA. The mysterious "urethral syndrome." *BMJ* 1991;303:1-2. (6 July.)
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Where should we train doctors in the future?

SIR,—In his article Dr Nigel Oswald outlines many arguments for teaching medicine within general practice and his vision of the future for this.¹ At King's College School of Medicine and

Dentistry the second rotation of a pilot scheme in which a general medical firm is taught in general practitioners' surgeries is now drawing to an end. This firm is the first of its kind in Britain and is considered to be a success by all concerned.

Medical students on the firm are allocated to individual practices for eight weeks and taught everything from the basics of history taking and examination to recognising heart murmurs. There are three half day sessions in the practice each week and seminars with the rest of the firm twice a week, at which interesting cases are presented. For each session in the practice two patients from the doctor's list are recalled, and the students must clerk and present them. After this more detailed teaching on these patients takes place. A different physiological system is tackled each week, the recalled patient being a "classic example of . . ." for example, a patient with rheumatoid arthritis.

One day a week is spent in hospital with a consultant for a teaching round and a medical outpatients session. A radiology tutorial and a teaching session on therapeutics also take place during the week. Finally, one night a week is spent on call in hospital.

Despite its being a full week the students have found it varied enough to maintain interest. This is helped by the general practitioner inviting the student to see his or her normal patients as well as the recalled ones if anything interesting arises. Other members of the practice know which "system of the week" the student is studying and do the same.

The students on the firm have all been impressed by the amount of consistently good clinical teaching they have received, despite initial reservations when they first heard that they had been allocated to this new firm. This is surely one of the most important guides to the success of any form of teaching. All too often students' opinion of the efficiency of teaching is not sought, when in fact feedback such as this should play some part in, if not form the basis of, the ascription of success or failure.

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- 1 Oswald N. Where should we train doctors in the future? *BMJ* 1991;303:71. (13 July.)

SIR,—Dr M J Evans's experiences in repeatedly failing the examination for membership of the Royal College of Physicians and subsequently leaving the profession are, in one way or another, common to most undergraduates and junior doctors, all striving for success in an archaic system that, by its hierarchical and closed nature, prevents reaction to it and thus change.¹

The problem with the solutions recently offered by Professor Robin C Fraser and Dr Nigel Oswald (more educational methods and more general practice),^{2,3} the General Medical Council (a slimmer core syllabus plus options and more integration),⁴ Abramson (a shift in the academic balance between teaching and research),⁵ and Weatherall (a move towards continuous assessment)⁶ is that they are all structural in nature. Although many of these are desirable and necessary prerequisites for change, my worry is that, as in the past,¹ they are unlikely to be implemented unless there is a considerable change in the culture of clinical medicine in the United Kingdom. This is a culture dominated by arrogant attitudes towards education that result in ritual humiliation at the bedside for students and juniors,^{1,7} a failure rate in final examinations of up to 30% at some medical schools,⁶ and the embarrassment of a preregistration year with little or no educational value.^{8,9}

Dr Evans is not the first to feel let down by the system^{1,7} and is unlikely to be the last. Getting out of this rut is going to take a long time and require