number of criteria including general fitness and performance on an exercise treadmill test. Of the eligible males, 32% underwent an exercise test, compared with only 9% of the women. Of these, 69% of men and 68% of women went on to participate in the outpatient cardiac rehabilitation programme. Because of the low uptake of women for an exercise test, however, the final figures for the percentage of patients who received outpatient cardiac rehabilitation were 35% for men and 17% for women. It would seem that failure to participate in outpatient cardiac rehabilitation arises at the time of the exercise treadmill test.

We matched women for age and next of kin. The mean age of women who underwent the exercise test was 60·6 years, compared with 72·4 years for those who did not. The mean age of those who had the test and went on to participate in the outpatient programme was 61·6 years, compared with 60·0 years for those who had a test but failed to go on to the outpatient programme. A total of 77% of women who underwent the test had a partner who was alive, compared with 37% of those who did not. In addition, 86% of women who went on to participate in the outpatient programme had a partner who was alive, compared with only 38% of women who took the test and then discontinued treatment.

Our initial findings suggest that age is a factor in determining which female patients undertake an assessment exercise test but not necessarily whether or not they go on to further rehabilitation. The support and encouragement of a partner, however, during assessment and treatment may be crucial in determining whether or not a patient continues with cardiac rehabilitation.

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Preschool screening for cryptorchidism

EDITOR,—James A Morecroft and Roger J Brereton[1] seem to have missed the point we made, which was to have early detection of undescended testes through the already existing screening programme (at birth, 6 weeks, 8 months, 18 months, and 3 years) and offer treatment of orchidopexy. What we believe is alarming is that among those operated, only 39% were below 6 years of age. There seems to be unacceptable delay in offering surgical treatment to those diagnosed as having undescended testes.

Morecroft and Brereton also misquote us by saying that 39·1% of boys underwent orchidopexy before the age of 2. Our letter refers to age below 6 and not 2.

Their suggestion of orchidectomy after puberty totally disregards the psychological effect it might have on those boys presenting after puberty. Moreover, diagnosing this condition for the first time after puberty only reflects on the quality of the screening programme and defeats the purpose of screening.

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Dispensing doctors

EDITOR,—The arguments for dispensing by general practitioners put forward by David Roberts are less than convincing, but pharmacist Gordon Geddes, and A J Morton-Jones and M A L Pringle, fail to address the fundamental issue since any comparison betwen doctors' and pharmacy dispensing does not compare like with like.[1-3]

General practitioners cannot charge a fee for any service, drug, or appliance, but chemists are allowed to charge fees and sell an ever increasing number of medicines on the GSL or P list over the counter.[4] As Morton-Jones and Pringle indicate, there would seem to be considerable differences between the prescribing habits of dispensing and prescribing doctors.[3] This difference is illusory and can wholly be attributed to over the counter sales by chemists of the cheaper preparations, which are not available to the patients of dispensing doctors.

The prescription charge is an unfair and inefficient tax which encourages self treatment. It is quite legal for chemists to sell prescribed preparations over the counter and in doing so it deprives the taxpayer of the prescription tax that would otherwise be paid. If the patient is exempt or the preparation costs more than the prescription tax the patient is unlikely to pay for it privately. The loss of these cheaper items from a prescribing doctor's prescribing analysis and cost (PACT) data increases the average net ingredient costs of medicines actually dispensed for the NHS and allows a further increase in the prescription charge to be introduced, a self perpetuating trend. Each increase in the prescription charge results in more patients purchasing keenly priced and heavily promoted "quality" medicines rather than the inferior generic preparations now available from the NHS at £3.75 per item.

In their survey of general practitioners' views of their extended role Spencer and Edwards failed to discuss the considerable disquiet felt by many doctors over the increasingly ambiguous position occupied by pharmacists.[5] Primarily business people motivated by profit, chemists sit apart from other members of primary health care teams, whose first allegiance is to the patient whether as employees of the health authority or of general practitioners.

If, as stated in the recent debate in the House of Lords,[6] pharmacists do provide a wider range of service more economically than any doctor, the government should forthwith relax the regulations and allow all general practitioners to provide the same service; but I fear the dispensing regulations will remain in their present form intentionally because depriving doctors of their medicines prevents them from practising medicine. This role is reserved for the new (private) apothecaries.

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Back testing devices

EDITOR,—I agree with Malcom I V Jayson that back testing devices are by no means lie detectors and should not be taken as final arbiters.[1] I believe, however, that by focusing solely on malingering Jayson has missed an important point about the use of these devices in compensation cases. True malingering is rare, and even patients who greatly amplify their symptoms are a minority. Most patients involved in medicolegal cases do have some impairment that deserves fair compensation, and the main problem is to quantify this handicap. Dynamometers for testing backs are useful for this.

This department has used an isoinertial device since 1988, in daily clinical practice and in more than 300 medicolegal cases. Careful observation and examination must remain an important part of the assessment as the physician's brain is still one of the most useful tools available. In low back disorders, however, a precise anatomical source of nociception cannot be recognised in most patients[2]; the physician will be guided by objective tests like Schöber's test or the fingers to floor distance and by his or her subjective impression, which may be influenced by the empathy between physician and patient. The back testing devices allow trunk function to be quantified more precisely, but this is possible only if the patient makes the maximum effort; thus the machines could be better described as truth detectors than lie detectors.

If patients do not make the maximum effort this does not mean that they are deliberately malingering or amplifying their symptoms. We can conclude only that, for some reasons a physiological maximal effort was not achieved, that we are not able to quantify the impairment, and that a more complete psychological assessment is needed.

Regarding the identification of maximal effort, it has been established that true maximum effort yields extremely reproducible results while deliberate submaximal efforts do not.[3-5] In the case of trunk testing, excessive illness behaviour correlates not only with poor performance but also with a higher variance.[6] Moreover, reproducibility is not the only criterion for assessing maximal performance; inconsistent performances suggest poor effort, for example when involuntary secondary axis torque in a given axis exceeds the voluntary performance when asked to demonstrate torque in the same axis.[7,8] Finally, observation during the test is important, and in medicolegal cases the examination must be performed by the physician who will write the conclusions and not by a technician.

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Doctors' legal position in medical emergencies

EDITOR,—Daniel Peckham raises the possibility that doctors who use common law to treat a life threatening drug overdose against the patient's wishes might subsequently face charges of assault.[1] A booklet prepared for members of the Medical Protection Society offers clear advice on this[2]:

In the case of a genuine emergency the practitioner may safely proceed to do what is reasonably necessary