arranged to suit practitioners' individual requirements. Doctors eligible under Section 48 of the N.H.S. Act (1946) may claim expenses from the Ministry of Health for attendance at these courses. Whole-time or part-time clinical attachments in particular departments can sometimes be arranged. Special arrangements are made for doctors who have not been practising for a period and now wish to return to active work.

Applications for clinical attachments including resident obstetric attachments will be considered.

Enquiries to the *Director of Postgraduate Medical Studies, University of Oxford, Osler House, 43 Woodstock Road, Oxford.*

University of Sheffield

Obstetrics for general practitioners

This course will be held in Sheffield from 7–12 July. Fee £10 10s. 0d. Accommodation available at one of the University's Halls of Residence at a moderate additional charge.

Geriatrics for general practitioners

A course in geriatrics for general practitioners will be held at the Northern General Hospital, Sheffield, on 12 and 13 July. Fee £4 4s. 0d. Overnight accommodation at the University Hall of Residence can be arranged at a moderate additional charge.

Applications for the above courses should be made to *the Postgraduate Dean, Faculty of Medicine, The University, Sheffield, S10. 2TN.* These courses are recognized by the Ministry under section 63 of the N.H.S. Act (1946).

URBAN HEALTH EDUCATION PLAN

The 23rd Summer School in Health Education to be held at Neuadd Reichel, University College of North Wales, Bangor, from 12–22 August, will be the first to be held under the aegis of the newly-formed Health Education Council, whose director-general is Dr W. T. Jones. The Director of the School will be Dr A. J. Dalzell-Ward, director of the field services division of the Council. The theme chosen this year is *A health education plan for an urban area.*

Further information including registration fee may be obtained from *the director, Field Services Division, Health Education Council Ltd., Lynton House, 7–12 Tavistock Square, London, W.C.1.*

OLD PEOPLE: A NEW LOOK AT THE SERVICES NEEDED

This residential course will be held in Madingley Hall, University of Cambridge from 20–27 September. The seminar is designed for those caring for old people as well as those responsible for the maintenance of social policy affecting the elderly. Doctors and members of both statutory and voluntary bodies will be welcome. A panel of distinguished speakers have been invited to present papers based on their experience and on current developments in medical and social care, and the seminar will study the rôle of local authorities, hospitals and voluntary bodies in the development of a policy for old people. Further details can be obtained from the *secretary, Board of Extra-Mural Studies, Stuart House, Mill Lane, Cambridge, CB2 1RY.*

SUMMER SCHOOL ON ALCOHOLISM

The School, which will be held at the University of Birmingham from 7 to 13 September 1969 is residential and will have a teaching programme on alcoholism in all its aspects—social and medical—and is intended for professional and para-professional people with a special interest in this field.

The cost will be 27 guineas.

Details can be obtained from *Mr P. D. Waters, Giles House, 23 Grove Park, London, S.E.5.*

Correspondence

General practice teaching of undergraduates in British Medical Schools

Sir,

I have just been reading Dr Harris' report and would like to congratulate him on an exhaustive and valuable paper. But I must take issue with his statement that "Attachment schemes started about 20 years ago with a scheme at St Mary's". An attachment scheme certainly existed in Aberdeen in 1945, and so far as I know had been running for many years before that. As I have not seen

this pioneering effort mentioned in any of the recent discussions on the teaching of general practice, I feel some details may be of general interest.

In Aberdeen there were several dispensaries where the poor could get free medical attention and, in their final year, students in groups of about six were attached to these dispensaries for one term of ten weeks. Each clinic was run by a general practitioner who held a surgery at 9 a.m. every morning except Sunday. In a typical session he would see about five or six patients, discussing the treatment of each with the group as he went along. After the surgery the doctor sorted out the requests for visits. Serious cases he would see himself, taking two students with him. Minor cases he allocated to pairs of students, who could either treat the patients themselves or report back to the doctor later in the morning for further advice.

Since we, as students, were accepting full responsibility for dealing with many of the cases, we used to over-visit appallingly—a case of measles would be seen daily for ten days—but we did learn in detail the natural progress of diseases seen in general practice. Also, since we were dealing with the most indigent section of the population, we got an early introduction to the more seamy side of home backgrounds.

By 11 a.m. we had to finish our visits and be back at the hospital to continue with normal teaching routine for the rest of the day.

The coming of the National Health Service saw the death of the dispensaries. Unfortunately the baby got thrown out with the bath water and no new attachment scheme was devised. I found the system provided a valuable experience, and I am glad to see interest reviving, but truly there is nothing new under the sun.

Cheltenham. WILLIAM A. WATT.

Presymptomatic diagnosis

Sir,

With reference to the above article (*J. roy. Coll. gen. Practit*, 1969, **17**, 237) may I make the following relevant and interesting points regarding a survey of eye diseases being carried out in my practice. Is screening by general practitioners worthwhile? Who should be screened, what technical and diagnostic criteria should be used and when and where should the general practitioner refer or start treatment? These are the questions thanks to Professor Perkins' reminders that one has to keep in mind.

In a single-handed practice with a list of over 3,000, and with heavy workload, one tends to limit the screening to simple yet important aspects of examination, i.e., routine examination, ophthalmoscopy, tonometry and history-taking in the form of a questionnaire. It is limited to patients over 40 years old, and the purpose is to probe into the preventive aspect to gather data about the incidence of eye disease affecting the vision, and to assess the practicability of mass screening with limited resources.

Screening of glaucoma patients reveals the following interesting points; firstly, in the chronic simple variety, which is initially asymptomatic, the problem is to detect raised intra-ocular pressure. Mass Schiotz tonometry has its hazards—i.e., high, false and negative findings; detection of ocular hypertensives who ultimately will not develop glaucoma; overloading of busy eye clinics with doubtful cases; undesirable effects of treating asymptomatic cases; family history of glaucoma and subjective visual symptoms. Suspicious cupping of discs usually associated with field defects are the main diagnostic criteria.

Presymptomatic screening of degenerative and various forms of retinopathy prevention-wise is of doubtful value except in cases of hypertension.

In geriatric cases cataracts with 'peripheral riders', uncomplicated by diabetic glaucoma, were left undone except where glasses were necessary. Early retro-chiasmal field defects picked up were mostly due to vascular causes.

In iatrogenic ophthalmology some lesions can be detected before they become irreversible. Extensive use of different varieties of drugs (chloroquine and psychotropic drugs) warrants a simple scheme, and possible subjective symptoms should be borne in mind.

Overloaded eye clinics, questionable values of mass screening, lack of resources and varying indications for treating asymptomatic cases do not make the job of the general practitioner easy, and therein lies the great dichotomy.

Blackwood, Monmouthshire. D. K. RAY.

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