

only practice to have continued with the system until now.

In 1977 there were 291 patients aged 75 years and over on the practice list. During 1977 254 of these patients (87%) were seen opportunistically — 57% were assessed to be at no risk, 37% to be at some risk and 6% at severe risk. Of those at no risk 9% were receiving services as were 34% of those at some risk and 31% of those at severe risk.

Nine of the patients who were not seen had moved, died or were in hospital. A follow-up visit was therefore made to the 28 patients (10%) who had not been seen. Twenty one patients (75%) were at no risk, six (21%) were at some risk and only one patient was at severe risk. Two unmet needs were identified — one for a nurse and one for chiropody.

Since 1977 the percentage of patients not seen has declined to approximately 5% and unmet need has virtually vanished.

Our experience confirms that opportunistic screening on patient initiated home visits and surgery attendances is a far more cost effective method of assessing the needs of the majority of elderly people than the time consuming formal home visiting of all elderly people required by the new general practitioner contract, provided that a proper system/card is effectively used at the annual opportunistic assessment. Perhaps the family health services authorities should monitor this, rather than randomly checking general practitioners' compliance with home visiting. This would be a more sensible way forward in the care of the elderly.

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### Standardized patients in general practice

Sir,

I was sad to read of the concept of standardized (simulated) patients as a means of assessing the performance of general practitioners (March *Journal*, p.94). This style of assessment smacks of a totalitarian state which plants stool pigeons in families, factories or prison camps to seek out the inefficient within the state.

I retired from general practice in 1984 when it was well known among the thinking minority of doctors that the quality

of general practitioners' work could be measured by the size of their list relative to the number of patients in their district and the number of practitioners in the district. It could also be assessed by the number of patients attending their surgeries. Patients recognize a caring and competent doctor and understand when a doctor is having an 'off day'. The general practitioner's triad of availability, amiability and ability in that order, was the way of life which I was taught, by my partner of 26 years, Tommy Granger.

No patient is able to assess a general practitioner on one consultation and vice versa. The assessment reported seems to be based on one consultation only. It takes weeks, months or even years for mutual assessment and for regard to develop. The simulated patient might see a doctor who had enjoyed only two hours sleep the night before because he did not use a deputizing service, a doctor whose child was ill with possible encephalitis, or a doctor who had a long surgery to get through and a long visiting list ahead of him. The doctor would treat the diarrhoea, headache or shoulder pain or check the patient's urine for sugar. This might be brief but he would investigate the condition at a future early date if the simulated patient returned.

I do not think that 'we could learn more about why doctors act as they do and evaluate how they provide their care' by this method. Let us not rely on stool pigeons to maintain the quality of general practice.

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Sir,

Standardized (simulated) patients (March *Journal*, p.94) seem an almost ideal method for large scale audit.

May I suggest that the Royal College of General Practitioners seek out large numbers of thespians who are 'resting between engagements' and put them to gainful employ all over the UK in a like manner to that described in the articles by Rethans and colleagues. The principle difference I propose would be for all RCGP members to be 'at risk' continuously unless they specifically opted out.

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### Screening for glaucoma in general practice

Sir,

Dr Lewis reports a small study on screening for glaucoma and the implications and limitations of an approach based on Perkins tonometry and fundoscopy (Letters, February *Journal*, p.80). Glaucoma is certainly a condition that satisfies many of Wilson's criteria, but applanation tonometry is a screening test that does not.<sup>1</sup> Dr Lewis found that half of the patients with a raised pressure on first measurement were normal on review. Published studies on ocular hypertension reveal similar problems to the normal distribution of arterial blood pressure and its variability within a patient over hours or days.<sup>2,3</sup> These factors, combined with the low annual incidence (1%) of glaucoma in patients with intraocular pressures over 22 mmHg, and the prevalence of 'low tension glaucoma' (10–20% of cases) mean that tonometry is not an ideal first line screening test. It proves even less useful when the cost of the skilled time necessary to detect each case is calculated. It is curious that Vernon has recently found the use of a pulse air jet tonometer so sensitive and specific in glaucoma screening.<sup>4</sup>

Another diagnostic test, fundoscopy, has many similar criticisms as a screening test, and is highly skill intensive. Even then, there is a surprising degree of inconsistency and unreliability when fundi are examined by experienced ophthalmologists.<sup>5</sup>

No mention has been made by Dr Lewis of field testing as a screening test for glaucoma. The strict diagnosis of glaucoma requires nerve fibre type field loss combined with raised intraocular pressure and vertical enlargement of the optic cup: disc ratio. The pioneering work of Hollows and Graham in the MRC Cardiff glaucoma screening study<sup>3</sup> showed the value of visual field testing and suggested that such screening could be done by trained assistants. Given the difficulty in establishing a meaningful diagnosis on the basis of pressures or disc appearance, it does seem more logical to screen on a functional basis for the pathological field loss, even though this is not an early event in the disease process. To date, the problems with visual field testing are that it relies on sophisticated, expensive equipment which the general practitioner does not have, is too time consuming to lend itself to population screening, and is not carried out systematically by those optometrists who do have the equipment.

An interesting portable, cheap, 'cardboard technology' field testing perimeter has recently been developed<sup>6</sup> which may allow nurses to screen large numbers of