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.[1] 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.[2,3] 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.[4]

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.[5]

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[3] 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[6] which may allow nurses to screen large numbers of

patients for field defects. General practitioners could then assess patients with such defects by fundoscopy and possibly tonometry before deciding who needs hospital based assessment. This oculokinetic perimetry test has shown adequate sensitivity in hospital trials[7] and its specificity is being evaluated at present. Once validated formally, this technique would allow a major screening programme to reduce the late presentation of a condition with major morbidity yet a long asymptomatic latent period.

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Calculation of the underprivileged area score

Sir,

The pertinent and timely paper by Chase and Davies (February *Journal,* p.63) shows that the current method of allocating additional resources to practices by the under-privileged area (UPA8) score, using 1981 electoral ward census data, is not sufficiently sensitive or accurate.

We practise in a large post-war council estate on the periphery of Bristol (Hartcliffe and Withywood). On this estate the unemployment rate is 30%, morbidity is at least twice the national average, and 11% of the population are children aged under five years (national average 8%). Among the families with children aged under five years, 66% have an unemployed major wage earner; in 70% one or both parents are under 21 years of age and 49% are single parent families. Thirty per cent receive support from social workers, probation services or the National Society for the Prevention of Cruelty to Children.

The *Poverty in Bristol* report, produced in 1988,[1] using indices measuring material deprivation, ranks our estate and St Paul's as the two most deprived areas in Bristol. The indices used were of total unemployment, numbers of children receiving free school meals, numbers of children subject to statutory supervision order, numbers of households with electricity disconnections, and distribution of housing benefits. The areas used were 'gazetteer zones', which are midway in size between electoral wards and the smaller enumeration districts. The link between poverty and poor health has recently been well documented in the debate about health inequalities.[2]

The UPA8 score for our ward of Bishopsworth, with a population of 25 702, containing Hartcliffe and Withywood is 11.64, the 12th most deprived in Bristol. The UPA8 score for the St Paul's ward, with a population of 7954 is 55.63, the most deprived in Bristol. This shows the importance of assessing small enough localities to ensure accurate targetting of resources for deprivation to areas with greatest needs, as Hutchinson has already indicated.[3] Thus, in our situation, the deprived nature of our patients has been diluted by relative affluence elsewhere in a large ward.

We are sure that Chase and Davies are correct in their assertion that many practices would find a discrepancy between practice- and census-deprived UPA8 scores. The concept of allocating additional resources in this way is an excellent way forward for deprived areas, but it needs to be fine tuned to where the real need lies. A method for appeal or negotiation is vital. As we have stated before, the problem of inequalities in health needs to be addressed urgently, as it is probably the most important health issue in the UK today.[4,5]

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The family history and the family doctor

Sir,

Dr Tomson's editorial on the importance of the family history (February *Journal,* p.45) gives a concise summary of one of the missed opportunities in general practice.

I suspect one of the reasons why we are falling down in this respect is because we tend not to build on what has been voiced, achieved, researched and developed by a minority of members and associates of the Royal College of General Practitioners and by general practitioners in general. The RCGP library can produce 53 references to papers dealing with the desirability of knowledge of the family history of our patients in our daily work, and a number make simple suggestions such as a rubberstamp outline of a family portrait on the back or inside of the A4 folder[1] or filing medical records in family bundles.

However, what astonished me even more than the failure to mention all the explorations by the RCGP in this area was that Dr Tomson was silent on the one classical contribution to this subject, *Family medicine, the medical life history of families* by F J A Huygen, a Dutch professor of general practice and honorary fellow of the RCGP. This book was recently republished by the RCGP.[2]

I do hope that the *Journal* will recognize the contribution of the ordinary general practitioner and encourage us to grab the opportunity presented by the increasing use of computing facilities in general practice, which should make cross-referencing to family morbidity less of a dream and more of a fact.

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Research in general practice

Sir,

The standard of research in British general practice is not good. I have, to prove it, a fat folder of papers which over many years I have been asked to referee; scarcely one is fit to be published in its submitted form. How can this be? I blame it on a lack of expert advice and support to researchers, the past lack of interest of the