perimeter has to be accurate in the community.

The value of oculokinetic perimetry administered by health visitors in the patient's home was assessed. Two hundred people aged 60–80 years were screened, only excluding those unable to read numbers on the test chart (one patient). The test was administered in accordance with previous studies[3] but in the patient's home under household lighting conditions, avoiding shadows on the test grid. The test was considered positive if while looking at any one (or more) number the patient reported that the spot disappeared and this could be repeated by administering the test for a second time at the same screening session. All patients with a field defect on oculokinetic perimetry were referred to the hospital.The false negative rate was not assessed.

Oculokinetic perimetry was quickly explained (20–155 seconds) and performed (20–167 seconds). Forty three patients (22%) were found to have a visual field defect following the test and were referred for hospital assessment. At the hospital a 25^0 central visual field was plotted using the Dicon 3000® autoperimeter (this test is 94% sensitive with 9% false positives for glaucoma[4]). After visual field testing a standardized ocular history and examination was performed. Eleven patients had glaucoma (Table 2). Of the patients with glaucoma six had had a normal intraocular pressure at initial intraocular pressure assessment at the first hospital outpatient visit.

Oculokinetic perimetry administered by non-ophthalmic personnel in the patient's own home recorded a much higher percentage of false positives (74%) than in previous studies on patients familiar with field tests.[3] Its use as a single screen for glaucoma would result in a high referral rate. In the United Kingdom, glaucoma screening has traditionally been performed by opticians. One limitation is that only those patients attending an optician can be screened. In our sample more than half of the population had not been to an optician within the last two years. Oculokinetic perimetry may be of use in screening these individuals who might not otherwise be examined. If general practitioners reviewed patients screened positive by oculokinetic perimetry, a higher sensitivity in hospital referral might be expected.

Table 2. Final diagnosis of patients screened positive with oculokinetic perimetry.

	No. of patients with diagnosis (n = 43)
Normal	21
Glaucoma	11
Congenital optic disc anomalies	2
Retinal vascular occlusion	2
Senile macular degeneration	2
Cataract	1
Hysterical	1
Retinopathy of prematurity	1
Non-attenders	2

n = number of patients.

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GP trainees

Sir,

Since 1950 the term trainee has described those doctors undertaking post-registration training for general practice.[1] These are qualified doctors who may sometimes be highly experienced. However, in common speech, a trainee is usually an unqualified person; *Roget's thesaurus* includes trainee with novice, debutant, greenhorn and probationer.[2] More than 10 years ago a general practitioner suggested that the term trainee should be abandoned.[3] However, it is still widely used.

A questionnaire survey was undertaken in order to examine patients' perceptions of the general practitioner trainee in a practice which had been training general practitioners for six years. Patients ticked boxes to answer yes, no or do not know. One hundred consecutive patients attending the surgery were given a questionnaire, and 84 questionnaires were returned. Table 3 shows the percentages of patients answering yes to each question.

Patients who expressed satisfaction with advice from the trainee and satisfaction with seeing the trainee in the absence of their usual general practitioner were significantly more likely to say that the trainee was a qualified doctor (59% of 29 versus 38% of 55, $\chi^2 = 5.44$, $P<0.05$ and 65% of 40 versus 27% of 44, $\chi^2 = 12.03$, $P<0.001$, respectively).

Table 3. Patients' perceptions of the general practitioner trainee and other practice staff.

	% of patients answering yes (n = 84)
Who is a qualified doctor?	
GP	*98*
GP locum	*85*
GP trainee	*45*
Medical student	*1*
Are you satisfied with advice from:	
GP	*94*
Practice nurse	*93*
GP locum	*64*
GP trainee	*35*
Medical student	*18*
If unable to see own GP, are you satisfied seeing:	
Different GP	*96*
GP locum	*76*
Practice nurse	*60*
GP trainee	*48*
Medical student	*20*

n = number of respondents.

Fewer than half the patients thought the general practitioner trainee was qualified; only one third of patients were satisfied with the trainee's advice compared with over 90% satisfaction with advice from the general practitioner.

Knowledge of the doctor's status was important. Those who thought the trainee was not qualified may have been less satisfied because of this perception. A general practitioner locum could be less experienced or less well qualified than a trainee but more patients were satisfied with the locum's advice than with advice from trainee.

More patients indicated they would be satisfied seeing the practice nurse than the trainee in the absence of their usual general practitioner. This could reflect the general high level of satisfaction with the nurse who is likely to have a longstanding relationship with patients. However, more patients preferred to see a general practitioner locum than either the nurse or the trainee. Locums are usually least well known to patients. The reason for these preferences may be that patients believe the general practitioner trainee is not qualified.

The term trainee is misleading to patients. Abandoning the term could increase patient satisfaction with these doctors. It is time for general practitioners as a whole to consider why they describe themselves by a low status term while training. Other branches of medicine have

devised neutral terms for their training grades, such as registrar. It will be a challenge for the profession to change a term of such longstanding use, but perhaps it is time to think of a more accurate description.

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List sizes

Sir,

One of our recent research studies involved practice list sizes over one year. Inspection of the list sizes for each of the four quarters revealed grater variation than expected and it may be helpful for other readers to record our experience.

In 1990–91, data had been obtained on practices in 20 family health services authorities, a total of 2700 practices. List sizes varied between 0 and over 27000. A total of 262 practices (9.7%) had a zero list size in at least one quarter, and clearly had to be excluded from most of the analyses. The mean list size over the four quarters for the remaining 2438 practices ranged from one to 27622. There were 68 practices with mean list sizes of under 1000 patients, of which 11 had fewer than 100 patients. Quarterly list sizes for the smallest and most variable of these practices are given in Table 4. To exclude atypical practices, an arbitrary minimum of 1000 patients was adopted, leaving 2370 practices (87.8% of the original 2700 practices).

We then investigated stability of list size over the four quarters. The maximum change (maximum minus minimum list size) was expressed as a percentage of the mean list size over the year. For practices with mean list sizes greater than 1000 this change ranged from 0 to 126%. A total of 1816 practices showed a change of up to 4%, 346 practices showed a 5–9% change, 122 practices showed a 10–19% change, 69 showed a 20–49% change, 15 showed a 50–99% change, and two practices showed a change of 100% or greater. Thus most practices remained fairly constant with changes of less than 20%. The practice with the largest change had quarterly list sizes of 653, 664, 2689 and 2785. For any analysis depending on measures per 1000 patients it is necessary to have stable populations. Exclusion of practices with changes of 20% or greater left 2284 practices (84.6% of the original 2700). The corresponding number for exclusion of practices with changes of greater than 10% was 2162 practices (80.1%).

Table 4. Quarterly list sizes for six practices with small list sizes or high variability.

Quarter	List sizes					
1	1	3	3	21	3	116
2	1	3	7	69	93	376
3	1	3	1	92	95	464
4	1	1	1	65	105	492

The presence of 10% of the practices with a zero list size in at least one quarter was surprising and an important consideration in our analysis. These zero list sizes were thought to be indicative of major reorganization. Small list sizes also occur when a few patients register with a practice in a neighbouring family health services authority (Wain K, Leeds Family Health Services Authority, personal communication). The explanations for zero list sizes and for small and highly variable list sizes are not entirely clear and readers may like to comment. It may be important in other research studies to be aware of our finding that when standardizing by list size, only 80–85% of registered practices were suitable for inclusion in the analysis.

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Refugees' health needs

Sir,

We wish to report the results of a pilot study seeking information on refugees' contacts with general practitioners in London in order to assess what special needs general practitioners perceive these patients as having, and the services available to meet these needs.

A random sample of 50 general practitioners were contacted from the London boroughs of North East Thames Regional Health Authority and a short semistructured interview was carried out over the telephone.

Thirty two general practitioners had seen refugees over the previous year (range 1–60 patients per doctor). Significantly more inner compared with outer London general practitioners had seen refugee patients (85% of 20 versus 50% of 30; $\chi^2 = 4.95$, 1 degree of freedom, $P<0.05$). No general practitioners knew the size of the refugee groups in their locality or the ethnic breakdown of their patients.

The problems general practitioners identified were diverse. Language difficulties were identified by 17 doctors. Nine general practitioners mentioned refugees' adjustment problems, while five described their own anxiety in trying to cope with the special needs of these patients who seemed to take up a disproportionate amount of time. Lack of information about previous treatment and uncertainty over continuity of care in the future added to the doctors' difficulties (mentioned by three doctors). Refugees' physical problems were identified by nine doctors and included injuries, chronic infections such as tuberculosis and the human immunodeficiency virus (HIV), and more general problems such as malnutrition and poor hygiene. Psychological problems, cited by six doctors, included patients being unhappy or extremely anxious. Six general practitioners were aware of histories of torture. Eight reported having seen patients with housing or financial difficulties.

Eighteen general practitioners had access to special services for refugees. For example, five described help with translation, and access to housing or a community centre through social services, while one each referred patients to a hospital based nurse liaison worker, a counselling service for ethnic minorities and a refugee officer who could be contacted through the family health services authority. Thirteen general practitioners made use of non-statutory services, including six who had referred patients to the Medical Foundation for the Care of Victims of Torture.

General practitioners described a number of difficulties using the services available. Local authority provision was sometimes seen as too bureaucratic or paternalistic (mentioned by two doctors), while some patients seemed embarrassed with voluntary workers whom they might know acting as translators in the surgery (two doctors). With all types of service there were difficulties in making contact in a reliable way.

Twenty four general practitioners saw a need for an increase in targeted services. Seventeen wanted more readily available interpreters or language training, particularly for the women refugees, and 12 wanted a service offering information and advice to refugee patients on how to find work and accommodation and in dealing