validated among other groups,⁵ has yet to be validated among British general practitioners.

RICHARD D NEAL
Research fellow

Centre for Research in Primary Care,
University of Leeds,
Leeds LS2 9LN

TEIFI JAMES
Research fellow in ophthalmology

Molecular Medicine Unit,
University of Leeds,
Leeds LS9 7TF

- 1 Pandit JC. Testing acuity of vision in general practice: reaching recommended standard. *BMJ* 1994;309:1408. (26 November.)
- 2 Sheldrick JH, Vernon SA, Wilson A. Study of diagnostic accord between general practitioners and an ophthalmologist. *BMJ* 1992;304:1096-8.
- 3 Featherstone PI, James C, Hall MS, Williams A. General practitioners' confidence in diagnosing and managing eye conditions: a survey in south Devon. *Br J Gen Pract* 1992;42:21-4.
- 4 Fink A, Wright L, Wormald R. Detection and prevention of treatable visual failure in general practice: room for improvement? *Br J Gen Pract* 1994;44:587-9.
- 5 Blackhurst DW, Maguire MG. Reproducibility of refraction and visual acuity measurement under a standard protocol. *Retina* 1989;9:163-9.

Many referral letters omit visual acuity measurement

EDITOR,—J C Pandit states that the visual acuity measured in a hospital eye department sometimes differs from that given in the general practitioner's referral letter.¹ In addition, many letters omit to give the visual acuity. We analysed 119 referral letters received last week by the eye department. Fifty one of the letters were accompanied by an optician's examination report suggesting a referral to the ophthalmic department.

Of the 68 referral letters not accompanied by an optician's report, only 10 recorded visual acuity; the remaining 58 did not mention it even though most of the patients were referred because of a subjective decline in vision. Of the 51 referral letters initiated by opticians, 49 mentioned the visual acuity. In addition, the general practitioners' referral letters often lacked vital information regarding the severity and duration of symptoms.

We suspect that this may be due to a lack of confidence in using the correct instruments and adjuncts such as pinholes to test visual acuity. Knowledge of the visual acuity may, however, be vitally important if the patient drives or lives alone. In addition, inaccuracies in the measurement of visual acuity by hospital practitioners occur,² with serious implications for subsequent management.

The visual acuity is the most important variable we assess when allotting clinic appointments and is invaluable in helping us to provide a responsive service. We urge all medical practitioners to regard visual acuity as an important variable to relay to the ophthalmologist when writing a referral letter.

G PRASAD RAO
Director, primary care in ophthalmology
ANTHONY P MORIARTY
Senior registrar, ophthalmology

St Paul's Eye Unit,
Royal Liverpool University Hospital,
Liverpool L7 8XP

- 1 Pandit JC. Testing acuity of vision in general practice: reaching recommended standard. *BMJ* 1994;309:1408. (26 November.)
- 2 Moriarty AP, Shilling JS, Williams CD, Lowy C, Smith SA. Assessment of retinopathy in diabetics newly referred to the diabetic clinic. *Practical Diabetes* 1993;10:70-2.

May not be reliable

EDITOR,—We take issue with J C Pandit's assertion that "measurements of acuity of vision are highly reliable."¹ To support this Pandit cites only one study, which adopted a test protocol quite atypical of that found in clinical practice.² Other studies of reliability report values considerably poorer

than clinical intuition would suggest, with an improvement or deterioration between test sessions often needing to exceed two standardised (0.1 log unit interval) chart lines in order to be deemed significant.^{3,5} Pandit's statement that "even a one line change in acuity may be of importance and should arouse suspicion" should therefore be viewed with some scepticism, particularly when additional signs and symptoms are absent.

MERRICK J MOSELEY
Lecturer

HELEN S JONES
Research fellow

PHILIP I MURRAY
Senior lecturer

Department of Ophthalmology,
Birmingham and Midland Eye Hospital,
Birmingham B3 2NS

- 1 Pandit JC. Testing acuity of vision in general practice: reaching recommended standard. *BMJ* 1994;309:1408. (26 November.)
- 2 Blackhurst DW, Maguire MG, Macular Photocoagulation Study Group. Reproducibility of refraction and visual acuity measurement under a standard protocol. *Retina* 1989;9:163-9.
- 3 Lovie-Kitchin JE. Validity and reliability of visual acuity measurements. *Ophthalmic Physiol Opt* 1988;8:363-70.
- 4 McElvaney A, Moseley MJ, Jones HS. Binocular inhibition of visual performance in patients with cataract: the influence of test reliability. *Acta Ophthalmologica* (in press).
- 5 Reeves BC, Wood JM, Hill AR. The reliability of high- and low-contrast letter charts. *Ophthalmic Physiol Opt* 1993;13:17-26.

Helps decide on urgency

EDITOR,—We were encouraged to learn that most general practice surgeries in the Torbay district have facilities for measuring visual acuity, even though not all of them are accurately set up.¹ Just as important is whether the general practitioners use these facilities to record visual acuity because, as J C Pandit points out, measurement of visual acuity is an important part of the ocular examination.

In a recent audit of referrals from general practitioners to our department over a month we analysed whether the patient's visual acuity had been included in the referral letter. There were 375 referral letters. Opticians had initiated 124 of these, and their records, containing data on visual acuity, were enclosed with the letter. Seventy four patients were children, in whom a measurement of visual acuity might reasonably not be expected. The remaining 177 patients were referred direct from general practitioners. The referral letters for only 35 of these gave the visual acuity.

We would encourage general practitioners to record the visual acuity in referral letters as it helps us to decide the urgency with which we need to see patients when booking clinics.

JAMES TALKS
Ophthalmic registrar
KATE LINDENBAUM
Associate specialist
BRYAN HOPKISSON
Consultant ophthalmologist

Eye Department,
Northampton General Hospital,
Northampton NN1 5BD

- 1 Pandit JC. Testing acuity of vision in general practice: reaching recommended standard. *BMJ* 1994;309:1408. (26 November.)

The price of truth

EDITOR,—Graham Pink graphically describes the scandal of the treatment of elderly people in the NHS.¹ "To comfort always" is now just a nursing and medical cliché. Pink's story will, of course, continue to be ignored or dismissed: it cannot be true; it must be rare; he exaggerates; he is over-sensitive and a trouble maker. In this way we will all reassure ourselves and continue with our busy preoccupations with saving lives (and making money).

This outrageous treatment of elderly people in

our so called civilised society receives little attention in the media, and we should ask ourselves why. Frail elderly people are largely silent and unseen. They have no political clout as a group, at a time when self interest is the dominant motivation throughout the land and only the rich have power, which they naturally wield on their own behalf.

The medical profession in the past has been distinguished by many social reformers, whose contribution to human welfare has arguably been greater than that of medical technicians and scientists. Surely there is one of our number among those practising geriatrics today who is prepared to mobilise public reforming zeal to right the wrongs that continue to be perpetrated against elderly and dying people in our selfish society. People with learning disabilities suffered similar neglect and indignities 30 years ago, and since then their lot has been transformed. The same revolution could occur in the care of elderly people if only self interest was discarded and all concerned people united in a crusade to change the political climate.

Pink has courageously shone a light on to the intolerable conditions that can still be found in some NHS facilities. His sacrifice should act as a spur to all of us to change the indefensible. Secrecy, the enemy of truth, must not be allowed to hide our shame.

JACK BAVIN
Retired consultant psychiatrist

Stroud,
Gloucester GL5 2LT

- 1 Pink G. The price of truth. *BMJ* 1994;309:1700-5. (24-31 December.)

Colour blindness in sport

EDITOR,—As one of the unfortunate 8% of people who are colour blind, I have not suffered greatly in playing cricket.¹ I have not been so lucky, however, with rugby. On the few occasions when brown leather balls were used on pitches surrounded by high grassy banks my need to anticipate the trajectory of a pass by focusing on the manufacturer's name printed on the surface of the ball neither made me a successful centre threequarter nor enamoured me to my team. Perhaps this could be the basis of the next study.

B O'CONNOR
Honorary registrar in anaesthesia

Department of Anaesthesia,
Bassetlaw District General Hospital,
Kilton,
Worksop S81 0BD

- 1 Goddard N, Coull D. Colour blind cricketers and snowballs. *BMJ* 1994;309:1684-5. (24-31 December.)

The internal market

EDITOR,—I hope I am not alone in finding Julian Le Grand's editorial on the internal market provoking and depressing.¹ Here we have a glimpse of the future NHS if untrammelled free marketeering is allowed to proceed. We are told that mergers of existing trusts would be allowed, provided a single organisation so formed would supply less than half the services in the "market" (in market speak, this is the area surrounding a hospital). This seems to rule out the concept of a district general hospital, which can, and should, provide most services to people in its geographical area. As usual, the marketeers are thinking in terms of large metropolitan areas and ignoring most hospitals, where competition is highly unlikely to benefit patients in the area.

Where purchasing is concerned, there may be some advantages in small groups, such as consortiums of general practitioners, commissioning services, provided a strategic overview is maintained. But the hatred of block contracts and the

multiplicity of small purchasing entities will create a nightmare of bureaucracy and subsequent waste without any clear benefit to patients in most cases.

The saddest and most threatening aspect of these guidelines, however, is the attitude towards cooperation between providers, which in future is to be looked on as collusion. The glory of the NHS has been the freedom with which clinicians, nurses, and workers in ancillary branches have been able to cooperate, to share, and thus to promote advances in treatment to the great benefit of patients generally and to ensure (through an equitable, national wage structure) a high and uniform standard of care throughout Britain. The market ethos with its suspicion of collusion and "industrial" espionage could destroy all that. I hope that readers will resolve to resist any attempt to limit their freedom to continue to cooperate with colleagues and to press for rational allocation of services in their districts and regions. At the same time a critical eye should remain firmly fixed on management and its costs, which have so dramatically increased since the onset of the reforms.

C A PORTER
Consultant paediatrician

Paediatric Department,
William Harvey Hospital,
Ashford,
Kent TN24 0LZ

1 Le Grand J. Internal market rules OK. *BMJ* 1994;309:1596-7. (17 December.)

Effect size

EDITOR,—In their article on the development of a symptom based outcome measure for asthma Nick Steen and colleagues erroneously define effect size as the difference between baseline and follow up scores divided by the standard error of baseline scores.¹ This is incorrect: the effect size is the difference between baseline and follow up scores divided by the standard deviation of baseline scores.² This mistake has been made by others.³

The purpose of calculating effect size is to determine whether a change in health status is clinically relevant and to permit comparison with other instruments, interventions, or studies. If the standard error of baseline scores is used as the denominator the effect size will increase roughly in proportion to the square root of the number of subjects in the study, negating these advantages. Guyatt *et al* recommended using twice the average within subject standard error derived from two or more baseline observations as the denominator to derive an index of an instrument's responsiveness.⁴ This index would increase roughly in proportion to the square root of the number of replicate baseline observations.

COLIN BORLAND
Consultant physician

Hinchingbrooke Hospital,
Huntingdon,
Cambridgeshire PE18 8NT

- 1 Steen N, Hutchinson A, McColl E, Eccles MP, Hewison J, Meadows KA, *et al*. Development of a symptom based outcome measure of asthma. *BMJ* 1994;309:1065-8. (22 October.)
- 2 Kazis LE, Anderson JJ, Meenan RF. Effect sizes for interpreting changes in health status. *Med Care* 1989;27:1178-89.
- 3 Fletcher A, Gore S, Jones D, Fitzpatrick R, Spiegelhalter D, Cox D. Quality of life measures in health care. II. Design, analysis, and interpretation. *BMJ* 1992;305:1145-8.
- 4 Guyatt G, Walter S, Norman G. Measuring change over time: assessing the usefulness of evaluative instruments. *J Chronic Dis* 1987;40:171-8.

Young people and drug misuse

EDITOR,—J Denham Wright and Laurence Pearl highlight the apparently increasing trend for young people to engage in illicit drug misuse.¹ There are, however, problems with the methods, analyses, and conclusions of their study. A large

generation and ideological gap exists between people who conduct this type of scientific inquiry and those who are the subjects of the research. Unfortunately, this is reflected in the design of the questionnaire, which opens with the question, "What drugs taken by addicts do you know?" While the word "addict" might reflect the social and moral mores of the late 1960s, its use nowadays to refer to young people who experiment with drugs is inaccurate and could be perceived as being derogatory. This can serve only to increase the gulf between the researcher and the researched, and as an opening gambit it casts doubt on the validity of the remainder of the research instrument.

The authors refer to television as being the main source of information about drugs and proceed to give recommendations to television producers on the basis of this. In fact, the main source of young people's information about drugs cannot be ascertained from this questionnaire since the question was "Where did you first hear about drugs?" The initial source of information and main source of information are not synonymous and should not be treated as such. The categorisation of responses to question 7—"Why do you think young people take drugs?"—is also dubious: some of the response categories seem semantically jumbled.

The authors quote Cohen as stating that primary prevention strategies have not reduced drug use among young people.² It would, I believe, be more accurate to state that the failures of traditional approaches to prevention or reduction were based on faulty assumptions, a lack of methodological rigour, and ignorance of young people's lives. There is, however, evidence that primary prevention programmes can work.³

Addressing the problem of young people and drugs requires competent interdisciplinary research that uses a combination of inductive and deductive research methods as a starting point. Quality control must be built in from the start.⁴ Without this, primary prevention approaches will have less than optimal chances of succeeding.

MERVYN GIFFORD
Research psychologist

Department of Public Health Medicine,
Eastern Health and Social Services Board,
Belfast BT2 8BS

- 1 Denham Wright J, Pearl L. Knowledge and experience of young people regarding drug misuse, 1969-94. *BMJ* 1995;310:20-4. (7 January.)
- 2 Cohen J. Achieving a reduction in drug related harm through education. In: Heather N, Wodak A, Nadelman E, O'Hare P, eds. *Psychoactive drugs and harm reduction: from faith to science*. London: Whurr, 1992.
- 3 Tobler N. Drug prevention programmes can work: research findings. *J Addict Dis* 1992;11(3):1-28.
- 4 Altman D. The scandal of poor medical research. *BMJ* 1994;308:283-4.

Press release of the week

EDITOR,—I hope that Patricia Macnair's views regarding the press release announcing a "major genetic breakthrough for Noonan syndrome" are not representative of those held at the *BMJ*. The discovery of a gene, whether for a rare condition like Noonan syndrome or for something much more common like breast cancer, is a major breakthrough for those at risk or affected. It shows that progress is being made and provides hope for the future. Publicity helps to communicate news of the discovery to those who might wish to know about it for personal or professional reasons and also to those who may be able to help raise funds to enable researchers to make further progress towards developing diagnostic tests and perhaps even a cure. The discovery of the structure of a gene is also a permanent addition to knowledge that will have timeless relevance, unlike some medical news afforded much greater prominence in the lay or professional press.

Macnair might consider why it is necessary to present the information in the way that it was presented. If the release had been headed "Minor advance for those with obscure disease—not many interested" I doubt that many people would have been moved to read it. The media make the rules about inclusion. The *BMJ* should not take the high moral ground if those with something to say play by those rules.

ALASTAIR KENT
Director

Genetic Interest Group,
London EC1M 3JB

- 1 Macnair P. "Major genetic breakthrough for Noonan syndrome." *BMJ* 1995;310:67. (7 January.)

Eradicating fleas

EDITOR,—As a pet owner and therefore a hierarchical owner of cat and dog fleas as well as a past user of aldrin and dieldrin (so only a pallid "green"), I will try to help Jacqueline Currey's carpets, if not her bites.¹ A relative who worked worldwide in agricultural pest control passed several tips on to me.

The house—Fleas breed in warm weather, and the pupas hatch simultaneously when stimulated by vibration (which equals good news to fleas, indicating that there is a meal about). So, on return from holiday, a room that has been the favoured snoozing place for pets can suddenly be "a-hop."

Cure—Purchase dichlorvos (Vapona) vapour strips appropriate to the largest room in the house: one strip controls about 56 m². Circulate the fresh strips, night by night, from room to room. The vapour is quite irritant, so close the doors well. Cats particularly are upset by it. Remember to treat the places, especially the airing cupboard, where pets spend time. This treatment acts on all stages of development of fleas: egg, larva, pupa, and imago. It penetrates into nooks and crannies and goes deep into carpet pile. Vacuuming leaves a suspect 2 cm around the skirting board and cleans only the surface pile of a carpet.

The pets—An old fashioned derris bath controls the animals' infestation. Make sure to get it well on the head and round the neck. It is amazing to see the number of dead fleas floating on the water afterwards. Let the derris dry on the animal, without rinsing. It leaves the bath in a disgusting state afterwards, alas.

A similar technique will control furniture beetle (woodworm) in lofts during the beetles' breeding flights in May.

BRUCE WILLIAMSON
Retired general practitioner

Melton Mowbray,
Leicestershire LE13 0NT

- 1 Currey J. Come back DDT—all is forgiven. *BMJ* 1994;309:1692. (24-31 December.)

Correction

Severe chickenpox during treatment with corticosteroids

Justin Bendig and colleagues have pointed out that the subtitle given by the editorial staff to their letter on this subject ("Commercial assays have high false positive rate"; 4 February, pp 327-8) is misleading. A more appropriate subtitle would have been "Latex assay shows false negatives."

Smoking and death

An editorial error occurred in this letter by Rodolfo Saracci (4 March, p 600). Parts (a) and (b) of the published figure are transposed and do not correspond to the legend or citations in the text. Therefore, the last sentences of the second and third paragraphs refer to part (b) of the published figure and the penultimate sentence refers to part (a).