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