Glaucoma

SIR,—With reference to the Bedford glaucoma survey (30 March, p. 791), the authors of this survey, among other things, set out to "assess the relative merits of various diagnostic methods for the detection of glaucoma." The methods used were tonometry, history of haloes or attacks of blurred vision, suspicious discs, and a family history of glaucoma.

Firstly, some of their conclusions are open to question. Without comparing visual field screening with tonometry they conclude, with nothing to substantiate such a conclusion, that "tonometry remains the single best test which does not require an experienced ophthalmologist to perform it." Unless a direct comparison between tonometry and visual field screening is made, like that made by Graham,[1] any conclusion made about the superiority of tonometry as a screening technique is seriously open to question. In fact Graham's conclusion in regarding the time spent per case detected, in spite of the fact that the field screener was a very early prototype, suggests that visual field screening is a significantly better method of screening for glaucoma. For each case detected he found it required by tonometry 11 ophthalmologist hours and 71 technician and secretary hours, while by visual field screener five ophthalmologist hours and 45 technician and secretary hours only were required. As the authors of the Bedford survey finally diagnosed glaucoma by the presence of field defects on a visual field screener, surely this would have been the best and cheapest way of conducting a survey for the detection of glaucoma. Secondly, the authors conclude that the total false-negative rate for tonometry was 10.9%, a figure arrived at because 6 cases out of 55 cases of primary glaucoma had normal tensions at survey. This, however, neglects any cases of glaucoma missed entirely at the time of survey.

Finally, it is of practical interest how unprofitable family studies in the survey proved. Of 70 cases who had a family history, only two proved to have glaucoma.—I am, etc.,

Royal Eye Hospital, London S.E.1. A. I. FRIEDMANN.

REFERENCE

1 Graham, P. A., *Proc. roy. Soc. Med.*, 1966, **59**, 1215.

Doctors of the Future

SIR,—The subject of medical education has received frequent prominence in your pages, culminating with the report of the Royal Commission (13 April, p. 109), and many highly commendable observations and recommendations have been made. I cannot help feeling, however, that a preoccupation with academic and scientific priorities has tended to exclude any real appreciation of the harsher realities of the outside world into which the newly fledged graduate must in due course emerge.

In the first place the intellectual demands on the student grow with every generation of entrants, and the type of graduate currently envisaged must surely represent an individual entitled to the highest degree of public respect and esteem. But in the context of the present social scene he will find himself thrust into a community increasingly dedicated to absolute egalitarianism.

However, one must welcome the emphasis which has been laid on the need for continuing postgraduate education. With a steadily increasing pace of technological progress one has to face the unpalatable fact that this is inseparable from a corresponding increase in the pace of obsolescence, and, while in former years the medical graduate has been comparable to a robust and soundly constructed piece of machinery, capable of giving a lifetime of useful service with negligible maintenance, today we are producing highly complex and delicate mechanisms. Our current practice of leaving them exposed to the corrosive effects of the wind and weather of our economic climate to function as best they may is only to invite early and irreparable breakdown. This is waste which can no longer be afforded.

But one word of warning must be uttered. We must be very careful, in our insistence on the need for a continuing surveillance of professional standards over an extended period of postgraduate development, that the Government officials who control our destinies do not seize upon the opportunity to relegate the doctor to the social and economic status of a perpetual probationer.—I am, etc.,

Area Laboratory, General Hospital, South Shields. D. M. MCCLURE.

Prescription Charges

SIR,—The introduction of the term chronic sick is imminent, and will bring a new class of people into British society. It is an unfortunate term. It is more likely to cause malaise and depression than well-being and improvement. Undoubtedly some people will welcome the personal classification "chronic sick," so that all their pharmaceutical requirements will be free. But it will be a stigma which many patients will resent.

The proposal to have two lists of drugs is not new and has been canvassed in your columns many times. It deserves further consideration. The first list of drugs, the life-savers, would be free, and would include preparations such as insulin and primidone. The second list would be paid for at the standard retail price. The allocation of drugs to the appropriate list could be settled by the committee responsible for the publication of the *British National Formulary* or *Proplist*. Doctors who have dispensing practices should be freed from the obligation of providing drugs in the second list. The introduction of a two-list formulary would avoid the need for the term chronic sick. At the same time those in continuous need would get their drugs free, while there would be a curb on the nation's drugs bill.—I am, etc.,

Swansea. G. D. REES.

Australia Next?

SIR,—The enthusiasm of Dr. F. H. Staines (23 March, p. 763) for general practice in Australia, to which Dr. E. C. Gambrill (27 April, p. 245) takes such exception, represented his personal point of view—which is presumably what you asked him to give. That this point of view is shared by most of us who have visited Australia may be ascribed to naiveté, coincidence, or collusion. That it is difficult to find any Australian general practitioner who is other than entirely happy in his job does suggest, on the other hand, that there is something to be said for it which cannot be said of the job in Britain which carries the same label.—I am, etc.,

Bude, Cornwall. ANTHONY BLOOD.

Gender and Sex

SIR,—In Personal View (20 April, p. 172) Mr. Patrick Trevor-Roper refers to the young of both genders. The problems of sex are surely complicated sufficiently without confusing them further with gender. I always understood that gender was invented by grammarians, whereas sex was considerably older and expressed physiological differences rather than linguistic ones. German cutlery (*das Messer, die Gabel, der Löffel*) involves three different genders, which seem to make sense to a German, but have little meaning for us. Siegmund Freud must have accepted as natural this multi-gendered concept of everyday things, but he became famous by concentrating on the more fundamental distinction between the two sexes.

If Mr. Trevor-Roper wanted to refer to the young in Germany he would find three genders involved (*der Mann, die Frau, das Mädchen*). The French too differ from us in the concept of gender in having only two where we have three, but, like the Germans and ourselves, they recognize the same two sexes. There is some precedent for the confusion of gender and sex, and a shop I know has a notice in its window "Pets neutered." While this is a picturesque description of the de-sexing process, as a physiologist I prefer to avoid the confusion of sex and gender and to call a spayed a spayed.—I am, etc.,

Department of Physiology, The University, Sheffield. D. H. SMYTH.

Points from Letters

Pensions

Dr. T. I. WILLIAMS (Llanelly, Carms.) writes: I was interested to read Dr. J. Kennedy Harper's letter (30 March, p. 843). It will interest all consultants who have given years of service to hospitals before the advent of the National Health Service to know that under the new compulsory contributory pensions scheme for Members of Parliament full credit is given for past services up to a maximum of 10 years.