practical benefit, and it seems possible that these forms could provide a model for an operation document to be employed whenever an adult is unable to give real consent, as may occur in dementia, psychosis, or obtunded conscious level.

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Dipstick haematuria and bladder cancer in men over 60

SIR,—The recent paper by Mr J Philip Britton and colleagues highlights an important point in regard to identifying blood in urine.[1] They found urinary tract disease in eight of 11 patients with a "false positive" result for blood on dipstick testing of urine—that is, when a positive dipstick test could not be confirmed by microscopy. Clearly, most of these dipstick results were not false. The authors allude to the difficulties of identifying red cells by light microscopy. Such difficulties are related in part to the method used, and Kesson *et al*[2] have shown that the quantitative method of urine microscopy is much more sensitive for detecting sediment abnormalities than the semiquantitative method used by Mr Britton and colleagues. A clinical study from this department has also shown that urine concentration is an important consideration in interpreting urine microscopy and that a "false positive" dipstick test for blood may be explained by urine of reduced tonicity, and therefore presumably red cell lysis.[3] As this study used phase contrast microscopy with quantitative methodology, even using this technique to verify a positive dipstick test for blood does not eliminate the risk of missing serious disease. Indeed, the report quoted by Mr Britton and colleagues as showing that urine dipsticks provide an accurate method of detecting red cells in urine when compared with phase contrast microscopy[4] showed none the less that not all patients with a positive dipstick test had an increased red cell count in urine. As well, all patients with one or more positive dipstick tests, who were fully investigated, were found to have underlying disease. Thus, contrary to the opinion in a recent review,[5] a positive dipstick test for blood that cannot be confirmed by microscopy should not be readily dismissed.

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Allocating resources to doctors in deprived areas

SIR,—Dr Allen Hutchinson and colleagues compared Jarman's underprivileged area score with Townsend's material deprivation score for allocating additional resources to doctors in deprived areas.[1] Different methods of assessing deprivation produce different results. This is clearly shown in our own practice, which is in a large, peripheral council estate in Bristol. The unemployment rate is 30%, morbidity is at least twice the national average, and the number of children aged under 5 is 10·8% (national average 8%). Among the families with children under 5, 66% have an unemployed major wage earner. In 70% one or both parents are under 21 and 48·5% 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 Jarman score for our ward of Bishopsworth, with a population of 25 702, containing Hartcliffe and Withywood (our practice area) is 11·64, the 12th most deprived in Bristol. The Jarman score for St Paul's ward, with a population of 7954, is 55·63, the most deprived in Bristol.

In contrast, the *Poverty in Bristol* report, 1988, using the indices of total unemployment, numbers of children receiving free school meals, numbers of children subject to a statutory supervision order, numbers of households with electricity disconnected, and distribution of housing benefits, and also using smaller "gazetteer zones," ranks Hartcliffe and Withywood alongside St Paul's as the areas of worst deprivation in Bristol.[2]

The contrast also shows the importance of assessing small enough localities to ensure accurate targeting of resources for deprivation to the areas with greatest need (which Hutchinson and others have recognised[1 3 4]). The use of gazetteer zones, electoral enumeration districts (information at this level will be available for the Jarman scores), and postcodes facilitates this degree of accuracy.

Once again, we make a plea for recognition of our large, peripheral council estates—the "forgotten areas of deprivation."[5]

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Prevention of blindness by screening for diabetic retinopathy

SIR,—Although we think it important to emphasise the need to prevent blindness due to diabetic retinopathy, we feel that Dr Thomas E Rohan and colleagues may be overoptimistic in their assertion that a national screening programme for diabetics could prevent 260 cases of blindness a year nationally.[1] They quote just one source for the sensitivity and specificity of ophthalmic opticians as screeners for diabetic eye disease,[2] in which only a quarter of those found not to require treatment were re-examined in comparison with the optimum standard. These were not a random sample, and if any bias was likely to influence response it would probably favour healthier subjects.

A multicentre study investigating the relative reliability of differing screening modalities and personnel including ophthalmic opticians has been completed but is not yet published. Early indications are that none of the different modalities reach anything like the sensitivity reported by Burns-Cox and Hart.[2]

Central to the success of screening for diabetic eye disease will be the sensitivity of the screeners, but even with a very high sensitivity, the poor coverage influenced by both attendance and an adequate register of those at risk will seriously undermine the expected achievements that Dr Rohan and colleagues suppose. They estimate an extra 14 200 diabetics requiring treatment and an extra 23 800 false positive referrals each year. For a hospital eye service that is already inundated, with many centres offering a two year wait for routine appointments, perhaps greater emphasis could have been placed on the resource implications of such a screening programme.

What is surely required is a randomised trial of screening using the most reliable methods for screening, whatever they turn out to be, so that the cost-benefit and feasibility of such a programme can be established. Dr Rohan and colleagues contribute little to the debate by reviewing existing data. The ethical considerations of a randomised trial will only be complicated by their conclusions.

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Lunar House

SIR,—I accept that the Home Office has a heavy workload.[1] The NHS has an even larger workload, but the government does not accept this as an excuse for slow service.

Mr Lloyd refers to the postal delay as "a number of weeks." My article referred to an eight to 12 week delay, which is the Home Office's own estimate—but in practice doctors have waited much longer. It is disappointing that the minister does not feel this merits an apology, let alone a promise of improvement.

My description of the casework officers was written after I spent nearly an hour in the waiting room at Lunar House—an experience that I doubt has been shared by the minister or his advisers. I described a clerk discussing holiday rotas because I stood beside his desk and listened to his conversation. I agree that the officers treat clients with sensitivity and politeness when the clients finally reach the desk. What concerns me is not that two thirds of officers are away from their desks at any one time but that half can be seen sitting at their desks apparently doing nothing, as described in my article.

I am pleased that the Minister has responded but disappointed that he has not replied to the specific points made in my article. His letter gives the impression that he believes that the present system works well. Messages I have had from doctors—and indeed the constructive letter I received from Lunar House itself—suggest otherwise. The system is unacceptable and requires improving.

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Embryo research

SIR,—One of the main failings of the Human Fertilisation and Embryology Bill is that it does not allow a free vote on embryo experimentation as promised by government spokesmen.

Clause 1(1) states: "References in this Act to an embryo, except where otherwise stated, are to a live human embryo where fertilisation is complete