

patients for field defects. General practitioners could then assess patients with such defects by fundoscopy and possibly tonometry before deciding who needs hospital based assessment. This oculokinetic perimetry test has shown adequate sensitivity in hospital trials⁷ and its specificity is being evaluated at present. Once validated formally, this technique would allow a major screening programme to reduce the late presentation of a condition with major morbidity yet a long asymptomatic latent period.

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Calculation of the underprivileged area score

Sir,
The pertinent and timely paper by Chase and Davies (February *Journal*, p.63) shows that the current method of allocating additional resources to practices by the under-privileged area (UPA8) score, using 1981 electoral ward census data, is not sufficiently sensitive or accurate.

We practise in a large post-war council estate on the periphery of Bristol (Hartcliffe and Witherwood). On this estate the unemployment rate is 30%, morbidity is at least twice the national average, and 11% of the population are children aged under five years (national average 8%). Among the families with children aged under five years, 66% have an unemployed major wage earner; in 70% one or both parents are under 21 years of age and 49% 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 *Poverty in Bristol* report, produced in 1988,¹ using indices measuring material deprivation, ranks our estate and St Paul's as the two most deprived areas in Bristol. The indices used were of total unemployment, numbers of children receiving free school meals, numbers of children subject to statutory supervision order, numbers of households with electricity disconnections, and distribution of housing benefits. The areas used were 'gazetteer zones', which are midway in size between electoral wards and the smaller enumeration districts. The link between poverty and poor health has recently been well documented in the debate about health inequalities.²

The UPA8 score for our ward of Bishopsworth, with a population of 25 702, containing Hartcliffe and Witherwood is 11.64, the 12th most deprived in Bristol. The UPA8 score for the St Paul's ward, with a population of 7954 is 55.63, the most deprived in Bristol. This shows the importance of assessing small enough localities to ensure accurate targeting of resources for deprivation to areas with greatest needs, as Hutchinson has already indicated.³ Thus, in our situation, the deprived nature of our patients has been diluted by relative affluence elsewhere in a large ward.

We are sure that Chase and Davies are correct in their assertion that many practices would find a discrepancy between practice- and census-deprived UPA8 scores. The concept of allocating additional resources in this way is an excellent way forward for deprived areas, but it needs to be fine tuned to where the real need lies. A method for appeal or negotiation is vital. As we have stated before, the problem of inequalities in health needs to be addressed urgently, as it is probably the most important health issue in the UK today.^{4,5}

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The family history and the family doctor

Sir,
Dr Tomson's editorial on the importance of the family history (February *Journal*, p.45) gives a concise summary of one of the missed opportunities in general practice.

I suspect one of the reasons why we are falling down in this respect is because we tend not to build on what has been voiced, achieved, researched and developed by a minority of members and associates of the Royal College of General Practitioners and by general practitioners in general. The RCGP library can produce 53 references to papers dealing with the desirability of knowledge of the family history of our patients in our daily work, and a number make simple suggestions such as a rubberstamp outline of a family portrait on the back or inside of the A4 folder¹ or filing medical records in family bundles.

However, what astonished me even more than the failure to mention all the explorations by the RCGP in this area was that Dr Tomson was silent on the one classical contribution to this subject, *Family medicine, the medical life history of families* by F J A Huygen, a Dutch professor of general practice and honorary fellow of the RCGP. This book was recently republished by the RCGP.²

I do hope that the *Journal* will recognize the contribution of the ordinary general practitioner and encourage us to grab the opportunity presented by the increasing use of computing facilities in general practice, which should make cross-referencing to family morbidity less of a dream and more of a fact.

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Research in general practice

Sir,
The standard of research in British general practice is not good. I have, to prove it, a fat folder of papers which over many years I have been asked to referee; scarcely one is fit to be published in its submitted form. How can this be? I blame it on a lack of expert advice and support to researchers, the past lack of interest of the