

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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References

1. Wilson JMG. Some principles of early diagnosis and detection. In: Teeling-Smith G (ed). *Surveillance and early diagnosis in general practice*. London: Office of Health Economics, 1966.
2. Eddy DM, Sanders LE, Eddy J. The value of screening for glaucoma with tonometry. *Surv Ophthalmol* 1983; 28: 194-205.
3. Hollows FC, Graham PA. Intraocular pressure, glaucoma and glaucoma suspects in a defined population. *Br J Ophthalmol* 1966; 50: 570-586.
4. Vernon SA, Henry DJ, Cater L, Jones SJ. Screening for glaucoma in the community by non ophthalmologically trained staff using semi automated equipment. *Eye* 1990; 4: 89-97.
5. Klein BEK, Moss SE, Magli YL, et al. Optic disc cupping as clinically estimated from photographs. *Ophthalmology* 1987; 94: 1481-1483.
6. Damato BE. Oculo-kinetic perimetry — a simple visual field test for use in the community. *Br J Ophthalmol* 1985; 69: 927-931.
7. Alvarez E, Damato BE, Jay JL, McLure E. Comparative evaluation of OKP and conventional perimetry. *Br J Ophthalmol* 1988; 72: 258-262.

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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References

1. Bristol City Council Planning Department. *Poverty in Bristol — an update*. Bristol: Bristol City Council Planning Department, 1988.
2. Smith GD, Bartley M, Blane D. The Black report on socioeconomic inequalities in health 10 years on. *Br Med J* 1990; 301: 373-377.
3. Hutchinson A, Foy C, Smyth J. Providing census data for general practice. 1. Feasibility. *J R Coll Gen Pract* 1987; 37: 448-450.
4. Main JA, Main PG. Health care in deprived areas. *Br J Gen Pract* 1990; 40: 41.
5. Main JA, Main PG. Allocating resources to doctors in deprived areas. *Br Med J* 1990; 299: 1528.

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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References

1. Cormack JJC. Family portraits — a method of recording family history. *J R Coll Gen Pract* 1975; 25: 520-526.
2. Huygen FJA. *Family medicine. The medical life history of families*. London: RCGP, 1990.

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

Royal College of General Practitioners in helping researchers and the manner in which the RCGP's Scientific Foundation Board has hitherto functioned. The past shortcomings of the College in this respect area, I think, generally acknowledged and, commendably, there is now a debate on how to improve the situation. The shortcomings of the Scientific Foundation Board are less widely recognized.

First, the reader should be aware that in respect of my own research I was given a grant of £409 in 1989 but I have been twice refused an extension in 1990. When I enquired about the reasons three were offered: there was a shortage of funds; the Foundation existed to 'prime pumps'; and it was perhaps desirable to give priority to younger applicants. There is, I submit, no shortage of funds available to the Scientific Foundation Board. Perusal of the College's annual report of 1989 indicates that four grants were for £10 000 or more and that much of the available money is being used to support underfunded departments of general practice. In particular in 1989 the Foundation gave £28 276 to two readers in the department of general practice of a London teaching hospital and in 1988 £6335 to a reader at a provincial one. However worthwhile this funding I think that it does not make the best use of the Foundation's funds.

Secondly, I know of no published evidence that the Foundation ever audits its decisions. This could be done by determining the proportion of grants which result in a publication in a refereed journal and counting the citation scores in the *Science citation index*. I know of one grant given in 1989 where the subsequent paper has been rejected by this *Journal*. Is there any evidence that the Foundation is getting a worthwhile return for its large investments?

Thirdly, the Foundation provides a point of contact with research enthusiasts in British general practice and its primary role should be an educational one. I never see it, in its present form, fulfilling this role. I think the Scientific Foundation Board would function better if it were replaced by a small research secretariat with a primary educational role and a secondary one of disbursing grants. A paid part-time epidemiologist of proven competence and authority should, as secretary, receive and screen all applications, enter into an educational dialogue with the applicant, follow up referees and assess the final modified application. The secretariat, composed of the secretary and two advisers, not associated with an academic unit, should then meet every two months, rather than every six months, to consider grants. There should also be a policy against

giving grants to academic units. Grants should be for the support of unattached individual researchers with funding on an annual basis and never exceeding £1000. The prospect of both money and expert advice might encourage trainees contemplating a project to apply. Gradually the educational benefit of such a system would seep into the very fabric of general practice and, as a proportion of trainers became more knowledgeable, the benefits would spread downwards.

The capitation method of paying doctors is idiosyncratic but does allow research possibilities denied to those who are paid by other methods. Our present contract may not be sustainable and time and space to do research may be short and vulnerable to future political changes. There should be a greater sense of urgency.

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Doctors with parkinsons disease

Sir,

Patients with parkinsons disease may suffer from uncertainty about the likely effects of the illness on their lives and, more specifically, their working lives. To help remedy this, a collection of 43 short autobiographies has recently been published by the Parkinsons Disease Society, under the title *Parkinsons disease and employment*.

Although a broad range of occupations was represented, no accounts by medically qualified patients were available. Since there are clearly many ways in which the experiences of 'doctor-patients' are likely to be particularly valuable, I am appealing to medically qualified patients suffering from parkinsons disease to send me short accounts of their illness. Anonymity of the contributors is ensured in any publication resulting from this project.

As a guide, it would be helpful if the account did not exceed three sides of A4 paper (about 1000 words). The following information would be useful:

1. Type of medical work: general practitioner, hospital, academic, other.
2. Chronology: age, age at onset of parkinsons disease, age at retirement.
3. Symptoms and diagnosis: self, general practitioner, consultant, other.
4. Treatment:
 - a. Medication and side-effects,
 - b. Surgery: thalamotomy, neuronal implant.

c. Rehabilitation, physiotherapy, speech therapy, conductive education, music therapy, other.

5. Interest in investigation of parkinsons disease: study of the literature, participation in clinical trials.
6. Effects of parkinsons disease on working life and relationship with patients: erosion of authority, increased sympathy for, and understanding of, patients' problems.
7. Effect of working conditions on ability to control parkinsons disease: stress.
8. Effects of illness on personal relationships: friends, family.

Finally, please send your contribution to me at the address given below. Copies of *Parkinsons disease and employment* can be obtained from The Welfare Department, Parkinsons Disease Society, 36 Portland Place, London WIN 3DG.

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Perfectly simple audits

Sir,

I wonder if general practitioners are being discouraged from carrying out audits by the proliferation of frightfully clever audits (FCAs) which are appearing in the medical press?

During last winter's snows my wife and I were worried about isolated elderly women and wondered how many of them could be contacted by telephone. We found that only 15% of women over the age of 80 years in the practice had telephone numbers noted in their medical records, and we felt that 80% would be an acceptable minimum. Searching the telephone book and checking other records enabled us to increase the number to 85%. We rang the secretary of the parish council with the names of those who had no one recorded as living at the same address and for whom we could find no telephone number and she sent round volunteers to see if they were in need of help.

This seems to me to have all the characteristics of a complete and productive audit. May I suggest that the *Journal* publish a series of PSAs (perfectly simple audits) to counteract the usual diet of FCAs?

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