

PRACTICE OBSERVED

Essays on Practice

Practice newsletter: three years' experience

PRACTICE PARTICIPATION ASSOCIATION

The Practice Participation Association of a Cambridge city practice produces a practice newsletter that contains details of activities of the association, information about the practice, and health information. Using a practice register, which is geographically based, copies of the newsletter are distributed to 5500 households to reach all 11500 patients who are registered with the practice.

In 1982 the practice employed a group worker to facilitate the development of self help groups and to explore ways in which patients might be encouraged to join a practice participation association. To attract the widest possible interest in these activities, a newsletter was produced. One copy was delivered to each household in which a patient of the practice lived, enabling information to be sent to all 11500 patients of the practice. This newsletter has been produced three times a year since and been given the title *Wishing Well*.

WISHING WELL

Newsletter of the Practice Participation Association
of 10 Household Practice & Day Hospital
ISSUE No. 8 September 1986


PRACTICAL ACTIVITIES GROUP

TAKEN FOR A RIDE

COMINGS AND GOINGS

PPA AGM

PPA GROUPS



What does the newsletter contain?

The original purpose of the newsletter was to advertise the formation of the Practice Participation Association. It also informs patients about self help groups, and advertises meetings on subjects related to health. The subjects have included children with asthma, osteopathy, when to call the doctor, cervical smears, acupuncture, food intolerance, and tomorrow's medicine. Through posters in the surgery, individual contact with patients, and the newsletter patients who are registered with the practice are informed about these meetings.

125 Newmarket Road and East Barwell Health Centre, Cambridge
PRACTICE PARTICIPATION ASSOCIATION
General practitioners and members of colonial group: David Anderson, Dr MORGAN CAMPBELL, Jo Bradley, Dr Hugh King, Val Neal, Helen Phillips, Dr Bernard Knox, Dr Peter Rowlands, Dr Norma Ross, Dr Nigel Oswald, Dr Martin Roland, and Willie Sugg
Correspondence to: David Anderson, 125 Newmarket Road, Cambridge CB5 8HA

any respiratory illnesses that are likely to predispose to poor respiratory health in the future. Defining such illness is necessary before trials of alternative methods of treatment that are designed to improve prognosis can be carried out.

This paper describes the patterns of respiratory illness in children who presented to general practitioners during the first year of life and relates these to several family and social variables that have been found to be important determinants of respiratory health in children. A second paper relates measures of ventilatory capacity at the age of 5 to respiratory illnesses in the first year of life.*

Methods

The study was done in two National Health Service group practices situated in the inner London Borough of Lambeth. All children who were born to mothers who were registered with these practices between 1 June 1975 and 31 May 1978 were eligible for inclusion. To compare the socioeconomic characteristics of those who left the study practices during the first year of life with those who remained, all children who were enrolled were classified into social groups using a classification of residential neighbourhoods (ACORN) (CACI Market Analysis Division, London WC1J 4DX). This is a social classification based on the characteristics of area of residence and requires only the identification of the individual's postcode to allocate the individual to a social group.

Throughout the first year of each child's life consultations with the general practitioner were recorded on special structured medical records. At consultations for respiratory illness the general practitioners recorded detailed clinical information on the presenting symptoms and physical signs. They distinguished first consultations from subsequent consultations in each episode of illness and were thus able to describe discrete episodes of respiratory illness. The records were checked for completeness by a research assistant after each consultation. At the child's first birthday a questionnaire was administered to the mother by a trained interviewer. This recorded the child's health during the first year of life, the health of the mother and father, and other social variables that were thought to have an important influence on the frequency of respiratory illness. The data were analysed using the regression techniques of the statistical package GLIM.¹ These techniques enable the effects of several factors to be examined simultaneously.

Definitions of respiratory illness—Diagnostic labelling of respiratory illness is notoriously unsatisfactory.² This was confirmed in this study by giving standardized notes to the doctors, who differed widely in their diagnostic responses. The doctors, however, reliably identified first consultations in episodes of illness and were consistent in whether they recorded the presence of an episode of "upper" respiratory illness, no recordings of adventitious lung sounds made at any consultation, (i) an episode of "lower" respiratory illness, one or more consultations at which adventitious lung sounds were recorded.

Results

Altogether, 554 infants were enrolled into the study. During the first year of the study, 152 (24%) moved away from the study practices. There was no significant difference between those who were lost to the study and those who remained with respect to sex and socioeconomic characteristics of areas of residence identified by the ACORN classification (see Methods). One infant died of a cot death at the age of three months. Of the children for whom there were complete consultation data, 404 (96%) of the mothers were interviewed at their child's first birthday.

Table 1 shows the frequency of consultations for episodes of respiratory illness. Only three children in the cohort were admitted to hospital with respiratory disease. Children with episodes of both upper and lower respiratory illness presented more frequently to their general practitioners in the summer months. Children with episodes of lower respiratory illness presented frequently during December, January, and February, with a peak in February in 1976, 1977, and 1978 and in March 1979.

Figure 1 shows the number of episodes of upper respiratory illness per 100 children over the four years of the study. For children born in the spring, summer, and autumn the incidence of upper respiratory illness peaked in the first winter after birth. Children who were born in winter appeared not to experience much upper respiratory illness in their first winter but showed a peak in the subsequent winter months, or children who were born in other seasons of the year. Figure 2 shows the pattern of lower respiratory illness according to the season of the year in which the child was born. Again a winter peak occurred in lower respiratory illness for those children who were born in the spring, summer, and autumn. Children who

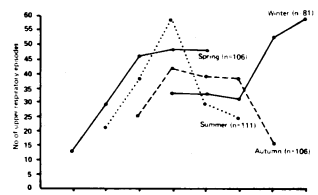


FIG. 1.—Number of episodes of upper respiratory illness per 100 children by season of birth.

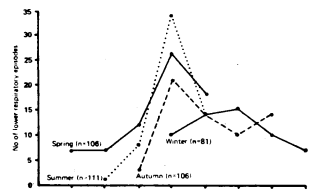


FIG. 2.—Number of episodes of lower respiratory illness per 100 children by season of birth.

were born in the winter months had no peak incidence of lower respiratory illness in either their first or their second winter.

Relation of upper and lower respiratory illness to episodes of non-respiratory illness

There was no relation between the frequency of consultation for non-respiratory illness and the frequency of consultation for respiratory illness. High consulting rates for upper respiratory illness were not related to consultations for lower respiratory illness. This suggests that those children with high consultation rates for respiratory illness were not just high users of medical care but that they experienced a much higher incidence of these illnesses.

Relation of consultation for respiratory illness to social and family factors

Information was collected about several social and family variables that were found in previous studies to be associated with increased frequency of lower respiratory illness (table 1). The attack rate of respiratory illness was evenly divided between the sexes. For children of parents who were in manual occupations there was an attack rate of lower respiratory illness of 70.4/100 compared with an attack rate of 37.5/100 for those whose parents worked in non-manual occupations. Lower respiratory illness was also reported more frequently in children who shared a room with another child, and parental symptoms of asthma. None of these was significant. In addition, no advantage was found in this study for infants who were breast fed as a term of protection against lower respiratory illness.

To test the independent effects of these social and family factors on frequency of lower respiratory illness in the first year of life, a multiple regression analysis was done using the factors listed in table 1. The parents' occupation remained an important factor even when taking into account sharing a room with an adult and parental smoking. Attack rates of lower respiratory illness in children born in manual occupations were estimated to be, from this model, 57.5/100 children (95% confidence limits

Details of self help groups are included in the newsletter. Usually between four and six groups function in the practice at one time. These have included relaxation, yoga for men, first time mothers, parents of teenagers, and groups for those who wish to lose weight or give up smoking. The newsletter also contains items of health information—for instance, on hypothermia, job, taking your temperature, food labelling, and immunisations for holidays. Other items have included news of staff changes, book reviews, articles on the history of the practice, details of fundraising events held by the Practice Participation Association, and local issues related to health.

The newsletter covers four sides of A4 paper. A typical front page is shown in the figure.

How is the newsletter distributed?

During 1982 the practice register was arranged geographically by volunteers to create a street index. It is thus possible to identify patients who live in a household, and labels are printed with the names of individual patients, one label per household. The task of reorganising the practice register of 11500 patients geographically would probably occupy a full time person for about three weeks.

Two voluntary managers organise the distribution of newsletters to individual households. One hundred and twenty volunteers have been recruited by advertisements in the newsletter and in the surgery. Most deliver 50 to 100 newsletters in a geographically limited area, usually near their homes. To meet the requirements of the local medical community that the newsletter should not be construed as advertising for the practice, each newsletter is folded in three, leaving the outside largely blank, and sealed with an address label.

The cost of producing each edition of the newsletter is approximately £150. This is met by the association, which has a successful fundraising group. The cost is low only because of the enormous amount of voluntary help offered by members of the practice. The self adhesive address labels cost £45 to produce for each edition, and

What does the newsletter achieve?

To assess what impact the newsletter has on members of the practice, a survey was carried out of patients' views of the newsletter: 178 patients who attended one of the surgeries and 42 patients who attended an open meeting of the association completed a questionnaire. Of these patients, 78% had heard of *Wishing Well*, most of whom knew that it was the newsletter of the practice association; 65% had read the last issue, though only 42% could remember a specific item in the last issue. Few patients made negative comments about the newsletter in the questionnaire, and no one has ever asked to be excluded from the delivery list.

There have been few spontaneous contributions from patients, but many people tell the deliverers that they welcome the newsletter, and several new patients have said how impressed they were by this evidence of community feeling in the practice. Delivering the newsletter is a simple task, and many people seem to enjoy having the opportunity to give something back to the practice in this way. Several have become group leaders or fundraisers, and the newsletter clearly performs an important recurring role for the Practice Participation Association.

Conclusion

The practice newsletter has been produced regularly for three years with voluntary help, and thus the cost can be supported by the Practice Participation Association. Delivering it to households provides an unusual way of informing all members of the practice of the association's activities. It is hoped that the newsletter helps to promote a feeling among patients that they belong to a practice "community."

* Accepted 16 July 1986.

Practice Research

Patterns of respiratory illness in the first year of life

C J WATKINS, Y SITTAMPALAM, D C MORRELL, S R LEEDER, E TRITTON

Abstract

This paper describes a study of respiratory illness during the first year of life in a cohort of infants who were born between 1975 and 1978 to mothers who were registered with two inner London group general practices. The types of respiratory illness and their relation to the season of the year and season of birth of the child are examined. The relations among the frequency and type of

respiratory illness and several social and family factors that have previously been shown to be associated with high levels of respiratory morbidity are also described.

Introduction

An association between various personal and family factors and an increased respiratory morbidity in children has been identified.¹ These community surveys have relied on the mothers' responses to questionnaires at interview about their infants' health to estimate the occurrence of respiratory illness. Such estimates have disagreed substantially with estimates derived from direct studies of respiratory illness in patients who have presented to attending general practitioners.^{2,3}

Most serious respiratory illness in infancy is managed by general practitioners. Apart from the need for accurate diagnosis and effective treatment for the acute illness, the problem for the attending general practitioner is to identify and treat appropriately

41.4-80.1) and 33.8-100 children (95% confidence limits 24.0-47.5) of parents in non-manual occupations.

This effect of the parents' occupation might have represented a difference in the propensity of the mother to consult for her sick child. Examining the frequency of consultation for non-respiratory illness by parents' occupation did not confirm this, suggesting that the high frequency of consultation for lower respiratory illness in children of those in manual occupations was due to a higher frequency of episodes of lower respiratory illness rather than a behavioural difference of the social classes.

TABLE 1.—Experience of respiratory illness recorded by the general practitioner in a birth cohort of 404 children

Experience of respiratory illness	No. of children
No respiratory illness	78 (19.3)
Upper respiratory illness only	177 (43.8)
Lower respiratory illness	149 (36.9)
Both	99 (24.6)
Two episodes	28 (6.9)
Three episodes	12 (2.9)
Four or more episodes	10 (2.5)
Upper respiratory illness only	290 (71.8)
All upper respiratory illnesses	290 (71.8)

TABLE 11.—Relation between several social and family factors and the attack rate of lower respiratory illness per 100 children per year presented in a birth cohort of 404 children

Sex	No.	Attack rate (per 100 children)	95% confidence interval	Significance level
Male	204	59.4	49.7-71.5	p=0.25
Female	200	54.5	43.5-68.1	
Father's occupation				
Non-manual	160	37.5	29.1-48.3	p<0.001
Manual	244	70.4	55.5-82.2	
Shares bedroom with adult				
Yes	179	42.9	34.5-52.7	p<0.001
No	225	68.5	53.3-88.1	
Parental smoking				
Neither	157	48.2	38.0-61.2	
Father only	80	71.0	55.3-89.0	
Mother only	11	50.9	36.7-72.1	
Both	118	57.6	43.9-72.2	0.05<p<0.1
Parental phlegm*				
Neither	249	56.2	47.4-66.2	
Father only	69	68.1	52.8-88.5	
Mother only	35	26.3	16.8-40.7	
Both	31	61.3	42.8-87.6	p<0.1

* Excludes 16 individuals on whom no information about father's occupation, smoking habits, or respiratory symptoms was available.

Discussion

Because of the wide interdoctor variation in the diagnosis of respiratory illness we have avoided using terms such as bronchitis, pneumonia, bronchitis, and wheezy bronchitis. For similar reasons we have avoided using "rhinocitis" or "croupation," for example, in describing lung sounds but instead have described the consultations for illness according to whether or not adventitious sounds were heard in the lung fields and defined episodes of respiratory illness accordingly.

The high peaks of respiratory illness in the winter months, and in particular the peak of incidence of lower respiratory illness occurring in the month of February, strongly suggest infection. In addition, the relative season of birth to respiratory illness further supports infection as a major factor. The lowest frequency of both upper and lower respiratory illness occurred in the first three months of life. The peak for both is in the winter months for children who were born in the spring, summer, and autumn. For those born in winter upper or lower respiratory illnesses were recorded in their first winter. In the second winter the expected seasonal peak of upper respiratory illness occurred, but a lower rate of lower respiratory illness was noted. Inherited maternal immunity presumably protects these children during the winter months

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