PRACTICE OBSERVED

Practice Research

General practice audit of asthma in childhood

MARK LEVY, LINDEN BELL

Abstract

It has been suggested that asthma is underdiagnosed in children. We studied the records of 52 children with asthma in our group practice. Although asthma had been positively diagnosed in roughly 10% of the children aged 18 months to 11 years, to make the diagnosis required an average of 16 to 20 consultations for respiratory problems. According to the symptoms recorded before the diagnosis was made, only three quarters of the children had presented with wheeze and roughly a third had difficulty in sleeping.

We think that the doctor's time would be better spent treating patients about their asthma than by repeatedly treating non-existent respiratory infection.

Introduction

It has been said that asthma is underdiagnosed in general practice possibly because of a reluctance to make the diagnosis.¹⁻³ The results of a recent study suggest that some general practitioners know only the common ways in which asthma may present in childhood.⁴ They may also be unfamiliar with current ideas about prophylactic and symptomatic treatment and are preoccupied with infection as the principal cause of recurrent respiratory problems in childhood.

We decided to find out how many children in our practice have asthma, note their presenting symptoms, and see how long it took doctors in an "asthma aware" practice to make the diagnosis.

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Patients and methods

We defined asthma as: (a) variable airways obstruction as shown by a history of recurrent wheeze, shortness of breath, or cough and a subsequent response to anti-asthmatic treatment; or (b) variation in peak expiratory flow rates of 20% or more, or both a and b.

From a list of 3900 patients in our practice in north West London we identified 470 children, aged between 18 months and 11 years, from the age-sex register. Those under 18 months were excluded because it is difficult to establish a diagnosis of variable airways obstruction. The results of a pilot study using 100 randomly selected patients showed that difficulty in sleeping may be an important early presenting symptom of asthma.

The following information was extracted from the records of children with an established diagnosis of asthma—that is, "asthma" was recorded in the notes and the criteria above were satisfied: (a) Date of first consultation with respiratory symptoms; (b) Dates of subsequent consultations for respiratory problems and nature of presenting symptoms; (c) Presenting symptoms: cough, wheeze, difficulty in breathing, difficulty in sleeping, unspecified—that is, presenting symptom not recorded; (d) Treatment: antibiotic, bronchodilator, cough suppressant; (e) Date of diagnosis of asthma; (f) Criteria for diagnosis (objective or subjective); (g) Whether the diagnosis was made in hospital or by the general practitioner.

Results

We identified 52 children with asthma—a prevalence of 11%. Of these, eight had been diagnosed in hospital and 44 by general practitioners. An objective diagnosis was made in 31 patients. The criteria for making that diagnosis was a variation in peak expiratory flow rate of at least 20%. A subjective diagnosis was made in the remaining 21 patients from a history suggesting asthma and a favourable response to bronchodilators or asthma prophylaxis.

Table I shows the age of patients when they consulted for the first time with a respiratory problem. Thirty five of the children with asthma presented with such symptoms before the age of 1 year, 10 in their second year, and by the age of 4 nearly all had presented for the first time.

Table II shows that only 16 of the 52 children with asthma had been diagnosed by the age of 4, despite 51 having already presented

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with respiratory symptoms by this age. Table III shows how many consultations for respiratory problems were made before a diagnosis of asthma was made. The range was from one to 48, with 17 patients requiring between 16 and 20 consultations and three patients more than 31 consultations. The patient who had had 48 consultations before asthma was diagnosed had been admitted to hospital on four occasions and discharged each time with a diagnosis of "wheezy bronchitis".

TABLE I—Age at first symptom

Age (months)	No. of patients	Percentage of total	Cumulative percentage total
0-1	18	34.6	34.6
1-2	17	32.6	67.2
2-3	6	11.5	78.7
3-4	6	11.5	90.2
4-5	1	1.9	92.1
5-6	1	1.9	94.0
6-7	1	1.9	95.9
7-8	1	1.9	97.8
8-9	1	1.9	99.7
9-10	1	1.9	100.0

TABLE II—Age at diagnosis

Age (months)	No. of patients	Percentage of total	Cumulative percentage total
0-1	5	9.6	9.6
1-2	5	9.6	19.2
2-3	3	5.8	25.0
3-4	3	5.8	30.8
4-5	3	5.8	36.6
5-6	3	5.8	42.4
6-7	3	5.8	48.2
7-8	3	5.8	54.0
8-9	3	5.8	59.8
9-10	3	5.8	65.6
10-11	3	5.8	71.4
11-12	3	5.8	77.2

TABLE III—Number of consultations before diagnosis for respiratory problem

No. of consultations	Total No. of patients
0-5	6
6-10	12
11-15	17
16-20	17
21-25	2
26-30	2
31-40	2

For the five symptom groups, taking all consultations into account, 50 (96%) patients presented at one time or another with cough, 39 (75%) with wheeze, 16 (31%) with difficulty in sleeping, 13 (25%) with difficulty in breathing, and in 47 (90%) the symptom has not been recorded. Before diagnosis of the prescriptions given to the children under 4 years, 43% (259) were for antibiotics, 17% (102) were for bronchodilators, and 40% (243) were for cough suppressants. For all the children diagnosed as having asthma, 365 (43%) prescriptions for antibiotics were given, 158 (19%) for bronchodilators, and 327 (38%) for cough suppressants.

Discussion

The prevalence of asthma in the group of children that we studied was 11%, the generally accepted range being 5% to 10%.⁵ The ages at which the children first presented with respiratory symptoms correspond with those in other studies.⁴ Only one third of the children studied had been diagnosed as asthmatic by their 4th birthday, despite all but one having presented with respiratory symptoms by this age. Antibiotics and cough suppressants were most often prescribed, indicating that infection rather than asthma was in the minds of the prescribing doctors, and only 17% of prescriptions were for bronchodilators. This raises why it seems "easier" to diagnose

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infection as opposed to thinking of other causes for the respiratory symptoms. The children with asthma in our practice were young patients were thought to have bronchoconstriction, which is usually attributed to "wheezy bronchitis," and bronchodilators were prescribed. But failure to note a diagnosis of asthma in the patient's record on these occasions usually resulted in inappropriate treatment being given at later consultations. We think that this happens because "wheezy bronchitis" implies a temporary disease, whereas asthma is generally viewed by both general practitioners and patients as a chronic and recurring problem.

A positive diagnosis of asthma is more likely to lead to appropriate treatment, reduce morbidity, and allow the doctor more confidence in educating the patient with asthma and their families. Furthermore, far fewer antibiotics and cough suppressants would be prescribed, at a considerable saving to the National Health Service.

The results of our study support the generally accepted view that cough is an early presenting symptom in asthma,⁴ but 25% of our patients did not complain of wheeze before diagnosis. Thus the absence of wheeze is not sufficient to exclude the diagnosis of asthma. A third of our patients had complained of difficulty in sleeping at some stage, though as far as we know this has not been mentioned in published reports. We think that this may be an important early distinguishing symptom of asthma and deserves to be included in the screening history of presentations for respiratory problems. Though we have a special interest in asthma in our practice, it was disappointing to note the high number of consultations for respiratory problems that were made before a diagnosis of asthma was confirmed.

We thank Dr Conrad Harris for helping with the initial design of the study, Dr M R B Forsyth for generating the random numbers, and Dr J L Bradley for help with the final draft. We are indebted to our staff at the Castle Road Surgery for their time and effort.

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ONE HUNDRED YEARS AGO

If we may take literally a statement published in the *New York Medical Record*, the "Heavenly Chime" must be a most satisfactory patient, for he invariably carries out instructions to the letter, is very grateful, and always pays his bill. The infant "Chime" is a very small baby as a rule, and does not average more than six pounds. In the arrangements for children, it would appear that there has a full appreciation of the importance of cleanliness, as napkins for the loola, they use a thick soft paper which looks like mullin, and they also use paper for protecting the bedding, one sheet being replaced by another as soon as it has become soiled. The paper is a stout, smooth, light brown fabric, not much like ordinary Western papers, and is prepared for use by crumpling and rubbing it with the hand. Being tough and thick, it is completely transformed by this process, and makes a soft fabric, almost impermeable to water, and admirably fitted for temporary protection to the bedding. This practice seems to have the great advantage of economy and cleanliness, inasmuch as the napkins and bed-protectors for each case are absolutely new, and therefore free from any possible taint of infection. It might be worth while for the benevolent persons who tend to poor living in women a "bag" of linen to take into consideration the possibility of using this cheap and cleanly substitute. (*British Medical Journal* 1884;235.)

Rethinking Established Dogma

Academic general practice

JOHN HORDER

A few weeks ago I was at a party when I was button-holed by an old acquaintance, a country general practitioner whom I had not seen for many years. It was only a moment before he launched into the attack—"What academics!" I supposed that he meant general practitioners who work in universities and "spray" their defence. After a few minutes, however, I realised that he included me. But am I an academic? What is academic general practice anyway?

Doctors, like everyone else, use words which stir feelings: these mean something as long as they are not examined too closely. French doctors are always talking about "médecine libérale." When I was working in France I counted 14 different ways in which these words were used. When turned on me they meant "We don't want the British National Health Service here." "Americans used to use 'socialised medicine' in the same way—some still do. It is nice to have a devil to knock."

Evidently academic general practitioners are the devil for my old acquaintance. Why? One can only surmise, and since he is not unique, it seems worth trying to do so. "They're not proper GPs, they don't practise full time, they have it easy." "They think they can tell others how to do the job and that they can do it better; but they don't have to work under the same pressures as the rest of us." "They're empire builders." They're always telling us something new that we ought to be doing—there's no change of sake—but they've lost touch with reality, we're busy enough without that. Our job is to look after patients."

There is a cluster of meanings in this composite image. If a general practitioner is not seen by patients under pressure he is not a proper general practitioner; much less so if he is doing some sort of different work; anything else is not really work. Then there are the notions of authority, privilege, superior knowledge, elitism, and ivory towers. This clustered image is especially imposed on those who are professors and lecturers in undergraduate medical schools—and, of course, on the Royal College of General Practitioners. Since I am now a visiting professor in a medical school and used to work at the college, must be doubly guilty, despite 30 years in an inner city practice.

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Prejudice

I hate saying it, but anyone who holds these views seems to have the prejudices of ignorance and perhaps envy too. It is so tempting to knock people who are like oneself, yet just a little different, especially if one does not meet them very much. It is a mere four centuries since Protestants and Catholics Christians killed each other in the main part of this kingdom for being just a little different.

Yet this feeling against academics is wide spread. Some of it even features in the *Concise Oxford Dictionary*, where I had hoped to find a true and just definition: "scholarly, abstract, impractical, cold, merely logical; member of a university; too much enslaved to the principles of an academy; merely theoretic arguments; university robes." So perhaps I ought to have been more sympathetic to my friend. On the other hand, the larger *Oxford Dictionary* has little of this and is altogether more constructive and generous to academics.

Within the medical profession the antagonism is certainly not confined to general practitioners, but it is easy to see why it should infect them as much or more than others. Until 30 years ago, with few exceptions, they saw themselves as practical men and women who could leave reflection, questioning, theory, research, even teaching to people in every branch of medicine except their own. They were themselves—most of us still are—the product of an undergraduate training by instructors drawn from every branch except their own. So perhaps I ought to have experience of their role. The role itself had not been defined, indeed most people thought that it could not be; it could therefore neither be taught nor developed through any process of teaching. Not surprisingly, it was not taught.

It was about that time, when change was welcomed after the destruction of war, that an old vision began to produce new beginnings in general practice. Dr Geoffrey Barber had actually started before the war to lecture at St Mary's Hospital, Paddington, but Dr Richard Scott was appointed to a formal university lectureship only in 1948 and a professorship in 1963. Original studies began to be published and a few courageous doctors lectured in front of their colleagues. The first integrated vocational training scheme started in Inverness in 1952, unknown to most people south of the Border. Dr Michael Balint's first group began to discuss the doctor-patient relationship systematically in 1953. Students began to go out to watch general practitioners at work. In effect, a small number of practitioners had accepted responsibility for thinking about, preserving, and developing their role in an increasingly specialised world. They had linked and organised themselves through a college. Something new had been grafted onto general practice which had been missing before.

If I assert that the new graft was in its essence academic, I use that word, like the larger *Oxford Dictionary*, in its meaning "scholarly, studious, collegiate." Clearly, it is to do with learning and teaching the practical tasks of curing, relieving, comforting sick people, preventing diseases, or promoting health, but it may be taken further than that. One reason which compels us to take

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it further is the experience of changing needs, changing knowledge, and changing organisations. It is no longer possible to keep young doctors where they will need their professional lifetime. Nor can a profession survive which does not look at itself and reflect on how its own role needs to respond to change or to institute it. This is why the General Medical Council has been urging for decades that medical schools should instruct less and educate more. It is why the reflective, questioning, critical element is needed within people whose apparent task is practical. This element, I believe, is the essence of meaning in a difficult world. It is something wholly positive and constructive. It depends in no way on authority, privilege, or ivory towers, but only on enthusiasm and on opportunities for enthusiasts to meet with authority and on opportunities for young doctors to meet with authority and on opportunities for young doctors to meet with authority.

Today there must be one general practitioner in every five who either has or has had experience of teaching students or postgraduate trainees. Many of them have studied how to teach. Perhaps one in 50 has published an original study, but far more hold regular case discussions or examine their own performance in some systematic way. These are all academic habits.

So, for me there is no dividing line between "academic" and "ordinary" general practitioners. Indeed, the idea that any doctor could be merely a practical worker responding to patient demand according to set habits of mind acquired long since seems ridiculous; none of us can survive without some source of inspiration, and this is the source of the challenge which we are constantly asked to question it and to decide which is right. But some do this more often and more deeply than others.

Challenges

It seems to me that it is these general practitioners who work in university medical schools who have to face the most severe challenges. To look after patients, to teach, to carry out research, to run a department, and to contribute to running a medical school is not an easier life than being in full time general practice. Not being available full time for patients stirs anxiety and guilt, not least when this is emphasised by "ordinary" general practitioners.⁶ So far from thinking that they know better, most academics are self-critical. At the same time they are in the difficulty with university colleagues who do not always understand the job of a doctor, since it is different from their own; even less do they understand the generalist, since they themselves are accustomed to a highly specialised environment. General practitioner

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academics might perhaps take comfort from General de Gaulle, who reckoned that as long as he was under attack from opposite directions simultaneously he must be on the right course. They may certainly take comfort from the high marks awarded to their contribution by students in every medical school.

Teaching students is, of course, the first responsibility of those who hold an appointment in a medical school. This is no longer just a matter of "exposing students to general practice" or of organising their attachments. The content of learning, its relation to the curriculum as a whole, and the methods of teaching demand constant revision. Tutors and students alike have to be drawn into the reflective, questioning task.

Some academic departments manage to contribute also to postgraduate vocational training and education, and some have made systematic efforts to develop relationships with those who practice in their local district. I believe that such contributions would multiply if more departments had more staff. Minimal staffing must be blamed for the present cuts, but these have in fact merely aggravated a situation that has never been satisfactory. Very few departments have been funded in a way that would allow them to contribute to postgraduate training and to the development of local practices as well as to undergraduate teaching. These seem to me to be ways in which the gap between "academic" and "ordinary" might be narrowed through personal contact and mutual encouragement.

I myself have been deeply grateful to have had increasing opportunities throughout my time as a clinician to enjoy the interplay between practice and theory. When I started such opportunities were few. I believe that all those who are general practitioners who have shared this experience, through learning, teaching, or reviewing their own performance or doing an original study, will have felt enriched by it. It troubles me that others still reject this gift as if it were alien or threatening. I see the academic as something which inevitably has a foothold inside every general practitioner, being put there by his choice of a thinking profession, by his education, and by the intellectual and emotional demands of his job. To deny this and to relegate it to some imagined ivory tower is a form of self deprivation and impoverishment.

I thank Dr Mary Boothroyd-Brooks, Dr Barry Brewer, Dr Christopher Donovan, Sir John Ellis, admirers of accurate diagnosis, Dr Elizabeth Horder, Professor Marshall Marinker, Professor James McCormick, Dr Peter Pritchard, and Dr John Wright.

skilled criticism, is that she has succeeded in producing a portrait of madness in one of its most interesting and least repulsive phases, which is equally artistic and faithful to nature. Pauline's madness is not, as stage-madness often is, an impossibility or bundle of inconsistencies provocative of laughter or disgust, but genuine melancholia atonitis, such as may be seen any day in the wards of our lunatic hospitals. It is melancholia atonitis of the first degree, born of its corner manifestations, and lifted into the region of poetry by the great, beautiful, and faithful to nature. Pauline's madness is not, as stage-madness often is, an impossibility or bundle of inconsistencies provocative of laughter or disgust, but genuine melancholia atonitis, such as may be seen any day in the wards of our lunatic hospitals. It is melancholia atonitis of the first degree, born of its corner manifestations, and lifted into the region of poetry by the great, beautiful, and faithful to nature. 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