

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.

WISHING WELL

Wishing Well newsletter content including 'PRACTICE ACTIVITIES TAKEN FOR A RIDE', 'COMINGS AND GOINGS', and 'PPA AGMS'.

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.

125 Newmarket Road and East Barrow Health Centre, Cambridge. General practitioners and members of editorial 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.

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.

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.

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 about the presenting symptoms and physical signs.

Definitions of respiratory illness—Diagnostic labelling of respiratory illness is necessarily unsatisfactory. This was confirmed in this study by giving standardised notes to the doctors, who differed widely in their diagnostic responses.

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.

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 the general practitioner than in the summer months.

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.

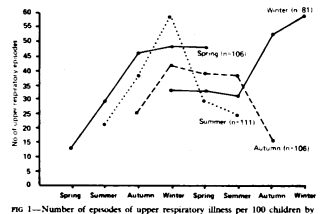


FIG 1—Number of episodes of upper respiratory illness per 100 children by season of birth.

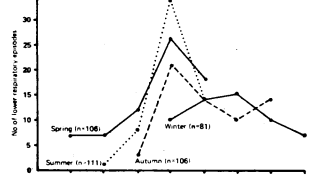


FIG 2—Number of episodes of lower respiratory illness per 100 children by season of birth.

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.

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 an increased frequency of lower respiratory illness.

To test the independent effects of this 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 II. The parents' occupation remained an important factor even when taking into account sharing a room with an adult and parental smoking.

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 covers four sides of A4 paper, and 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.

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

this is met by the practice—the only cost to the doctors of the newsletter.

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.

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.

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.

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41.4-80.1 and 33.8-100.0 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.

Table with 2 columns: Experience of respiratory illness and No. of children. Rows include No respiratory illness, Upper respiratory illness, Lower respiratory illness, Both, and Total.

TABLE II—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.

Table with 5 columns: Sex, No., Attack rate per 100 children, 95% confidence interval, and Significance level. Rows include Sex, Father's occupation, Parental smoking, and Parental phlegm.

\* 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 "rhinovirus" or "viral" as examples, 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.

immediately after birth. By the time they are exposed in the second winter their defence mechanisms have matured sufficiently to protect them from infection. The results of this study can be clarified only when simple methods of identifying viruses and of measuring the immune status of children become available for use in general practice. Studies carried out in hospital are unlikely to be helpful—only three of the 404 children in our study were admitted to hospital.

In this study the role of family and social variables is not as clear cut as that reported by Leeder et al. The striking finding in this study is the social class difference in frequency of consultation for respiratory illness, with high consultation rates for those whose fathers were in manual occupations. This is not explained by the fact that the families from which such children come are more likely to live in overcrowded conditions nor that the parents are more likely to smoke and have a productive cough nor that mothers of such children were less likely to breast feed. The fact that the propensity to consult for non-respiratory illness was similar for children whose fathers were in manual and non-manual work indicates that this is not a behavioural characteristic but is a true representation of the different frequency of occurrence of respiratory illness according to parents' occupation.

Several conclusions arise from this study. Episodes of lower respiratory illness, defined as those in which there were one or more consultations at which adventitious lung sounds were recorded, are particularly frequent in the children of manual workers. They cannot be explained by the many social and family variables examined in this study such as overcrowding, smoking habits, parents' respiratory symptoms, and breast feeding.

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Practice Research

Patterns of respiratory illness in the first year of life

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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. 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.

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

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