

## Relative support groups

IT is well-known that the statutory and voluntary services (with the exception of the home-help service) play little part in supporting the elderly in the community<sup>1</sup> and that confused elderly people are cared for mainly by their relatives at home. The caring relatives are often isolated and under stress; adequate and appropriate support must be provided for them if the care of the elderly in the community is to be improved.<sup>2</sup> In this issue of the *Journal* there is a discussion of developments in the field of community health which highlights the emergence of community health initiatives. These may be particularly valuable for the carers of disabled and confused older people. Groups providing support for relatives of the elderly are useful and their formation is to be encouraged.

These 'relative support groups' usefully have at least one professional in attendance. The professionals involved may include general practitioners, social workers, nurses, occupational therapists and psychiatrists. They are able to give some input to the group, but are also able to perceive the reactions and stresses of the various carers. Relative support groups have some of the elements of self-help groups. Individuals can benefit from the sharing of experiences, with members offering each other empathetic support and advice. Practical support and counselling from a fellow sufferer has great value.<sup>3</sup> Some relative support groups are set up by voluntary organizations or charities, such as the Alzheimer's Disease Society, but others may be organized by social services or health districts. Too few groups currently exist, however, and too little is known about them and the value of their work.

The kinds of problems discussed by the relatives may be related to the behaviour of the confused elderly person, for example wandering, incontinence, or aggressive behaviour. There may, however, be problems that are related to the carers themselves, such as physical infirmities, feelings of isolation, and feelings of frustration centred on missed career opportunities, or there may be practical matters to discuss, such as accommodation and finance. Many relatives are concerned about long-term care; it is common for carers to suffer feelings of guilt and inadequacy about allowing their loved ones to enter residential care. Some people will talk at length about the former life of their confused elderly relative, almost as if he or she were already dead; the

term 'living bereavement' has been used to describe this state.

Relative support groups deal with the problems of carers by considering each difficulty and offering some type of solution. The help may involve practical advice from those who have had similar experiences, for example coping with shopping, or bathing difficulties. However, a large component of the help is the mutual recognition that feelings of frustration, anxiety about institutional care and concern about bereavement are shared by many members of the group.

Professional workers within the relative support group act as facilitators or counsellors, and should try to help the group find its own solutions to the problems raised. The professionals involved gain much from the group, particularly in their understanding of the problems and needs of the carers of confused elderly people. We are still a long way from finding a biological solution to dementia. The urgent needs remain the provision of adequate services for the elderly and the active support of their caring families.<sup>4</sup> Regular meetings of the caring relatives seem to have many advantages, both for the relatives and for the professionals involved.

Relative support groups are one example of community health initiatives which are self-help groups, community health groups, or community development health projects. The inclusion of professional workers within relative support groups, which would otherwise be self-help groups, helps break the traditional barrier between the expert professional view and the suffering patient or caring relative. Consideration of social systems alongside health experiences and the role of the voluntary sector is particularly useful for the primary health care team.

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## The third national study of morbidity statistics from general practice

IT is impossible to make rational decisions concerning the allocation of resources within health care services without good information about patterns of health needs. Need is notoriously difficult to define and measure. There may be differences between medical and sociological concepts of need and even more problems emerge when attempting to give priorities to different health needs. This challenges us to produce the most comprehensive and objective assessment of need possible. Information about resource allocation, and by implication about health need, can be gained from morbidity surveys. These surveys can be based on total populations, as in the General Household Survey, on hospital patients, as in the Hospital Inpatient En-

quiry, or on consultations in general practice. The organization of family care in the United Kingdom is particularly useful in providing information on morbidity patterns because the list system provides a denominator which permits the calculation of prevalence rates of illnesses and health problems.

The preliminary results from the third morbidity survey in general practice which was carried out in 1981 are published in the *Office of Population Censuses and Surveys (OPCS) Monitor* and are distributed with this issue of the *Journal*.<sup>†</sup> Like its predecessor (the second national morbidity survey), this third

<sup>†</sup>Except those mailed overseas. Readers from abroad who require a free copy of the *Monitor* should apply to: Dr D.M. Fleming, RCGP Birmingham Research Unit, Lordwood House, 54 Lordwood Road, Harborne, Birmingham B17 9DB, UK.

survey was conducted using a diagnostic index to record morbidity. The coding of morbidity was based on a modified version of the ninth *International classification of disease (ICD-9)* which was compatible with that used in the second national morbidity survey and also with the *International classification of health problems in primary care — second series (ICHPPC-2)*. The coding was designed to minimize large entries in the remainder categories. The population denominator for the study was obtained from the practice age–sex registers which had been validated against the registers held by the family practitioner committees. It has to be recognized that both population figures may be inflated by a small unknown amount — probably by about 5%.<sup>1</sup> Also like its predecessor, the third survey was conducted in a year of national census and, through a confidential linkage procedure, the material will be analysed with respect to census information.

A full analysis of the study material from which this *OPCS Monitor* provides extracts will be published later this year and analysis of the census-linked information is scheduled for publication in 1987. The survey covers one year's recording in 48 practices with a total registered population of approximately 300 000 persons served by 146 general practitioners. The study population was representative of the national population in respect of age and sex. The behaviour of the general practitioners in the study, however, may not be representative of the national pattern and there are weaknesses in the precision of diagnostic labels in general practice. Nevertheless, the size of the survey ensures that the morbidity events recorded and the data on use of health care obtained provide a good guide to the national picture of general practice in 1981.

Consultation rates are one of the areas where a superficial

comparison can be made with the second morbidity survey. In 1971, 62.2% of the male population and 70.0% of the female population consulted the general practitioner (rates standardized to the population of the present study); in this study the figures are 65.2% and 76.6%, respectively. The mean consultation rates in 1971 were 2.30 per annum for males and 3.14 per annum for females; in the 1981 survey they are 2.71 and 4.02 respectively. Rates for home visits as a percentage of all consultations were 14.0% for males and 15.8% for females in 1971 and 11.1% and 12.7% respectively in 1981. A more detailed comparison of the results for 1981 with those for 1971 will follow in due course.

One strength of the morbidity data from the third national survey lies in the rigorous methods of recording — standardized methods were employed and exhaustive validation exercises were carried out. The participating practices are to be congratulated on the high quality of recording of information and this aspect should not be forgotten when looking to the future and in particular towards 1991, the year of the next census. The arrival of computers in practices has greatly increased the accessibility of data on morbidity and the use of primary care facilities but we should be careful that the increasing quantity of information does not blind us to the need to maintain the highest standards in the recording of information in general practice.

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## Delay in diagnosing asthma — is the nature of general practice to blame?

IN 1978 Speight drew attention to the underdiagnosis of childhood asthma in the community.<sup>1</sup> He ascribed this mainly to general practitioners' reluctance to use the term asthma. Subsequent studies confirmed that asthma was underdiagnosed and as a result undertreated in the community.<sup>2-4</sup> An audit in general practice found a delay in the recognition of childhood asthmatics.<sup>5</sup> In this study it was found that children consulted their general practitioner with respiratory symptoms on average 16 times before a diagnosis of asthma was entered in the records.<sup>5</sup> In the same practice it was found that asthmatic children consulted significantly more frequently than children without asthma.<sup>6</sup> Toop found that general practice records predicted asthma in 50% of his population sample of asthmatics.<sup>7</sup> Although most asthmatic children consult their doctors, often repeatedly, with respiratory symptoms, only 50% of cases of asthma are diagnosed by the age of five years.<sup>5,8,9</sup> The consequences of not diagnosing asthma are all too evident in the literature.<sup>2-4,10</sup> Failure to recognize asthma, and therefore to treat it appropriately, may result in loss of schooling, misery due to being left out in sport, growth retardation, family distress and in some tragic cases, death during an attack of asthma.

With all this information available, why then are we not diagnosing asthma earlier? As general practitioners, we are in a favourable position to recognize and manage asthma in the community. The nature of our work enables us to continually supervise and educate families with chronic illness such as

asthma. It is sad that we are failing to relieve the family distress which results from an undiagnosed asthmatic child, and we need to look at the weaknesses in the present organization of general practice to find possible aetiological factors.

The average consultation still only lasts about six minutes. It is therefore understandable that asthma can be overlooked, since often the diagnosis depends upon taking a good history.

Even in single-handed practices it is conceivable that a patient may see a number of different doctors when consulting over a period of time. As a result a child may consult repeatedly for respiratory symptoms, without the doctor realizing how often the child has attended. If the doctor consulted does not take a past medical history, or check back in the records for previous respiratory consultations, asthma will often go undiagnosed. The clues are in the records,<sup>5,7</sup> but as with most medical problems, if asthma is not considered the diagnosis will be missed. More emphasis should be given to establishing personal lists to avoid patients consulting many doctors in a practice.

When patients change general practitioners their records often take many months to be transferred. It is conceivable therefore that the new doctor could be unaware of past recurrent respiratory consultations unless a detailed past medical history is obtained from new patients.

The disadvantages of using a term such as wheezy bronchitis or other euphemisms for asthma far outweigh the advantages. The belief that patients and parents need to be protected against