

rig 2—The probability of having at least one, two, etc, visits at different average visiting rates. (The smallest values are at the top.)\*

can expect no new visits. Fig 2 shows why. The horizontal axis is the average daily visit rate. The vertical axis is the probability of the event occurring. The curved diagonal lines represent the probability of having at least one, two, three, or more visits. My own average visiting rate is 12 a day, and this is represented by the dotted vertical line. Going back to the practice with lower visits and a long back to the practice with curve, visits a desired thomset extended time for 10 a day. This is an event which is probably not going to occur as often as once in four years.

It used to be possible to rush through 15 or 20 patients, santh a cup of coffee, and get out on the real business of the day doing visits. Years ago when I first went into practice I had to do 20 visits on the same day. I think it is a fear of break of the control of the cont

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## Practice Research

## Mental illness in inner London

CONRAD M HARRIS

From the perspective of general practice, hospital data indicating that the prevalence of mental iliness is much higher in inner London than elsewhere in Britain may be misleading. A study in five inner London practices found morbidity parterns for mental disorder similar to those recorded in a national survey.

Figures from sources outside general practice, such as hospital and other data quoted in A Survey of Primary Care in London,

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indicate that the prevalence of mental illness is much greater in inner London than in other parts of the United Kingdom with, for example, high rates of suicide, addiction to narcotics, and admission to mental hospital. Is it safe to assume, therefore, that an inner London general practitioner's experience of looking after the mentally ill is very different from that of general practitioners' deschedere?

### Methods and results

Methods and results
Five practices located in Kensington, Chelsea, and Westminster or
in Camdon and Islington collaborated with the department of general
practice of St Mary's Hoopiand Medical School from 1979 to 1981 to
collect data shout all their patients and consultations. The data used
22 244 registered patients. As expected in this part of London, the
proportion of young adults and the ratio of women to men were both
very high, consultation rates along distents' consulting rates have
Wales for 1981 to facilitate comparisons with other sources of data, the
calculations being based on five year age groups for men and women.
Up to two diagnoses could be recorded at each consultation, they
were made without agreed criteria and coded according to the number

BRITISH MEDICAL JOURNAL VOLUME 288 12 MAY 1984

BRITISH MEDICAL JOURNAL. VOLUME 288 12 MAY 1984 children who show any signs of illness go through a complex process of decision making, which includes reference to past experience, the advice of others, and the estimation of risk, cost, and likely benefits. 'I Blazere and Paterson, in a detailed study of families in social classes IV and Vin Aberdeen, showed that families who were likely to consult less than other families, and they suggested that the mothers might both perceive illness in their children less readily 10 consult less than other families, and they suggested that the mothers might both perceive illness in their children less readily and also consult less readily. 'Collins and Klein reanalysed data in the General Household Survey and concluded that there was no evidence for "over usage" of general practice by people in poorer socioeconomic groups, and that the reverse might be true.'

In the supplies the supplies of the decision to consult are different for adults and children,'s ow decided to study the consultation patterns of children in samal urban general practice to identify socioeconomic factors that might be associated. The aim of the study was to relate children's consultation patterns to social factors and to attitudes expressed by mothers about their children's health.

Method

A long established single handed Dundee practice, based in the doctor's house, was taken over by the university department of general practice in 1977 and after two years in sparate premises it moved to a new health centre with two larger practices. During the study period (1962-3) three established practitions; fuembers of the study period (1962-3) three established practitions; fuembers of the study period (1962-3) three established practitions; fuembers of the study of the study. The study of the study during the study of the study of the study of the study.

CONTACT RECORDING

All face to face contacts with doctors were recorded on contact sheets, noting the type of contact (doctor or patient initiated, and at home, in surgery, or in a baby clinic), and up to three problem statements. Doctors were tasked to record only sufficient details cause of disorder or disease, if known. Casualty attendances were recorded from the duplicate hospital notes, routingly sent after each attendance. The problem statements were coded according to the International Classification of Health Problems in Primary Care\*. The international Classification of Health Problems in Primary Care\* at the midpoint of the study (under 2 years, 2 to 4, 5 to 7, 8 to 11). All contact data were entered on to computer fit for snashyst using SPSS (statistical package for the social sciences) on the Dundee University DEC 10 computer. University DEC 10 computer. We have a superior of the study (under 2 years, 2 to 4, 5 to 7, 8 to 11). By JG, using a semistructured format, to obtain basic socioelomographic data and sito her answers to a test of knowledge of children is these and to a scenario instrument to assess her intentions in hypothetical illness. A From the contact data the number of patient instated with decreasing contacts with age (table I) to a standardized index with decreasing contacts with age (table I) to a standardized index were decided to control for age of child and number of children in the family: Age standardized consultation index. — (Sum of observed contacts, where expected contacts were the average for each age group.

The problems that had been recorded on contact sheets were classified into the main ICD (International Classification of Diseases)

groups and further amalgamated when numbers were small. Table I relates to contacts initiated by the family, usually the mother, and table II to contacts initiated by the doctor or health authority (in the case of immunisation and screening). All such presentive wolk was gradient in overall contact rates, most contacts initiated by patients showing the same trend, but only prevention in the doctor initiated contacts.

Because the same coding was used these trents are directly comparible with published results from the test for a friendly comparible with published results from the test for a friendly comparible with published results from the test for all conditions, for three groups of conditions, and for one specific diagnosis. There is a

TABLE 1—Distribution by age and problem category of 502 contacts ini-patients during the study year (rates per child in parentheses)

	Age group (years)						
ICD group	Under 2 (n = 39)	2-4 (n = 48)	5-7 (n = 42)	8-11 (n ~ 54)			
I Infections	28 (0.7)	17 (0.4)	13 (0.3)	16 (0:3)			
V and VI Mental and sense organs	34 (0.9)	35 (0.7)	16 (0.4)	9 (0.2)			
VIII Respiratory	42 (1:1)	51 (1.1)	45 (1-1)	24 (0.4)			
XII Skin	15 (0.4)	12 (0.3)	7 (0.2)	4 (0:1)			
XVI Symptoms, signs, and ill							
defined conditions	15 (0.4)	11 (0:2)	11 (0.3)	16 (0.3)			
XVII Trauma	15 (0.4)	10 (0.2)	6 (0-1)	12 (0.2)			
All others	10 (0.3)	6 (0-1)	9 (0.2)	8 (0 1)			
All conditions	159	142	108	93			
Overall rates per child per year	41	3.0	2.6	1.7			

ICD - International Classification of Diseases

TABLE II—Distribution by age and problem category of 273 contacts initiated by doctor during study year (rates per child in parentheses)

	Age group (years)						
ICD group	Under 2 (n = 39)	2-4 (n = 48)	5-7 (n = 42)	8-11 (n = 54)			
I Infections V and VI Mental, nervous system	2 ()	2 ()	6 (0-1)	5 (0 1)			
and sense organs	10 (0-3)	21 (0.4)	24 (0-6)	2 ()			
VIII Respiratory	9 (0.2)	12 (0-3)	21 (0.5)	6 (0-1)			
XVIII Preventive	75 (1.9)	31 (0.6)	9 (0-2)	2 ()			
All others	9 (0 2)	4 (0-1)	2 ()	9 (0.2)			
All conditions	106	74	65	28			
Overall rates	2 7	1.5	1.5	0.5			

TABLE 111—Comparison between study data and Second National Morbidity Survey (1970-1)

Source: Age group:	NMS (0-4)	Dundee (0-4)	Ratio	NMS (5-14)	Dundee (5-11)	Ratio
All conditions	3.63	5.53	1.5	1.93	1.06	1.6
Infections	0 26	0.56	2.2	0.22	0.42	19
Respiratory	1 26	1.31	1.0	0.66	1 00	1.5
Prevention	0.60	1.22	20	_	-	

noticeable discrepancy that requires explanation. Consultation rates north of the border are generally reported to be higher than in England. The difference in age rouping for the older age group might have a small effect on those figures, but the lower age groups might have a small effect on those figures, but the lower age groups are exactly comparable. Angie in practice core the 12 years between the studies. Otherwise, the difference probably represents a difference in illness behaviour of this small group of mothers compared with a very large sample of the general population. We wished to identify those families in which one or more children We without others of the smaller of the sm

## ting to mental disorders: five inner London practices (1980) compared with the second National Morbidity Study (1970-1) (NMS2)

-1		All mental disorders		ziety	Depr	ession	Schizophrenia		Alcohol dependence and drug dependence			
	Study popula- tion	NMS 2	Study popula- tion	NMS 2	Study popula- tion	NMS 2	Study popula- tion	NMS 2	Stud	iy popul Drug	tion Total	NMS 2
Consultations/1000 patients No of consultations as "o of total No of individuals consulting/1000 patients	239° 10 96°	298 10 110	63° 27 41°	73 2:5 34	94° 40 41°	105 3-5 36	0.69	6-4 0-15 1-4	14° 054	5* 0 21 2*	19* 0.75 8*	2-6 0-07 0-8

revision of the International Classification of Diseases (ICD).<sup>1</sup> There were 80 893 consultations, including 3874 with temporary residents; 101 277 diagnoses were recorded, and 20 818 individuals consulted at least once. Of the 7966 consultations for mental disorder, 448 were

least once. Of the 7966 consultations for mental disorder, 496 were with temporary residents.

The table shows findings from the study population, together with statistic derived from the second National Morbidity Study, which provides the most readily comparable data. "The rates for the study population include emporary residents in the numerator but not in the demonitance," managination that is particularly subward but which reflects realistically but work of the practices.

Discussion

There are inherent problems in comparing the two sets of data. Neither study laid down firm criteria for diagnosis, and diagnosic fashion may well have changed during a decade. Some combining of data has been required to equit the headings of the eighth revision of the International Classification of the region of the overall annual consultation rate of the London practices was only 2.5 per patient, even with temporary residents added to the numerator, whereas that of the national sample was 3.0. The London doctors could record two diagnoses for each patient, and did so in a quarter of their consultations, but the doctors of the earlier survey were allowed only one. Despite these problems, the similarity of the two sets of data for mental disorder as a whole suggests that comparisons may still be valid. The most striking feature of the data is that anaxey and depression are found with roughly equal frequency in the two

surveys, but the figures for schizophrenia and for alcohol and drug dependence are very much higher in London. Though there is little doubt that the difference is a true one, these three conditions are not common enough to affect the overall pattern of morbidity genetity: anxiety and depression account for about two thirds of the mental illness in both samples. Since the figures from the five practices are closely similar overall to those of the practices in the national study it seems fair to conclude that data which demonstrate a much greater psychiatric morbidity in London are misleading in the context of general practice.

The principals of the practices participating were: D Cohen; L Jacobs, A Evans, and F Willis; B Jarman, A Elder, and M Constantinious; L Newman, A Antoniou, D Litter, L J Stringer, and I Derin; and M Wilks and C Wag. The work was part of a project funded mainly by the Department of Health and Social Security, and I am grateful to B Jarman and P White for help in creating the recording system and method of standardisation.

<sup>1</sup> Royal College of General Practitioners. A survey of primary care in London. Occasional paper 16. London. RGCP, 1981.
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\*Office of Population Consuses and Surveys. Morbadity statistic from general practice, round natural study 1979-71. London: BMSO, 1974.

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# Child consultation patterns in general practice comparing "high" and "low" consulting families

PETER D CAMPION, JENNET GABRIEL

All children's consultations with their general practitioner over a 12 month period in a small urban practice were analysed. Overall consultation rates ranged from 22 per child a year for 8 to 1 year olds, to 88 for those under 2. Families were grouped according to their average rate

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of new consultations for children, standardised for age. Families with higher consulting rates scored higher on an index of economic disadvantage, with mothers who scored higher on a test of "tendency to consult" and who were less educated than those in lower consulting families. The presence of any doctor-defined "significant disease" in any child was highly correlated with the family's consultation rate.

## Introduction

"Illness behaviour," the processes by which symptoms are differentially perceived, evaluated, and acted on, is the normal antecedent to the act of consulting a doctor, particularly the general practitioner. Thus it has been shown that parents of

TABLE IV-Diagnoses used to classify families as "significant disease present"

Problem	No of families with any episodes	Total No of contacts	Per cent of all contacts
Acute otitus media	37	91	12.4
Bronchitis	24	45	6.1
Asthma	- 1	18	2.4
Pneumonia	2	3	0 4 2 3
Allergic rhinitis		17	2.3
Eczema	11	12	1-6 0-9 0-7
Urinary tract infection		7	0.9
Delay in development	•	5	0.7
Rehaviour disorders	2	21	29
Non-suppurative otitis media	ž	2	0.3
Anaemia	1	3	0.4
			***

TABLE V—Cross tabulation of family consultation index (quartiles) with presence or absence of significant disease in any child

	Consultation index				
	Low	Medium low	Medium high	High	Total
Any significant disease present at least once	7	11	20	23	61
No significant disease present	21	16	10	5	52

z' = 22 26; 3 df; p = 0 0001.

TABLE VI—Differences in sociodemographic variables between highest and lowest consulting families (high and low quartiles)

Variable	Mean (low consulting families)	Mean (high consulting families)	,	р
Age of youngest child	4:3	43	-0-07	NS NS
Age of mother	31 6	28 5	1 84	NS
No of children Mothers' educational level	20	17	1.74	NS
(scale of 1 to 4) Fathers' educational level	2 64	1 62	3 75	0.001
(scale of 1 to 4)	2-62	2 10	1-61	NS
Economic factor*	- 0.25	0.54	- 3 18	0.002
Scenario action score*	13.4	16.5	- 2 42	0.02

\*See text. NS - Not significant.

"disease variable" was far more important a predictor of overall consulting rate than any socioeconomic variables when all variables the doctor when a serious problem is present, but they attend more often for other problems when a serious problem is present, but they attend more often for other problems when a serious problem has been present. The relation of some of the social and economic variables to the consultation index are shown in tube VI. Families have been divided and lowest consulting quartiles compared for the variables shown. The economic factor was derived by factor analysis from three variables, an economic index (financial state, employment state), a housing index (tens, standard of housing, and occrewosting), and socre was based on whether or not the mother would consult in 10 hypothetical stutions. Higher consulting families were found to be statistically significantly poorer, the mother wound is some state of the statistically significantly poorer, the mother wound is some state of the statistically significantly poorer, the mother worm on the worm on the statistically significantly poorer, the mother worm on the worm on the statistically significantly poorer, the mother worm on the worm on the statistically significantly poorer, the mother worm on the worm on the statistically significantly poorer, who have a mother worm of the statistically significantly poorer, which is the statistically significantly poorer, which is the statistically significantly poorer, which is the statistically significantly poorer, the mother worm of the statistical significant the statistical

BRITISH MEDICAL JOURNAL VOLUME 288 12 MAY 1984

# Discussion

BRITISH MEDICAL JOURNAL VOLUME 288 12 MAY 1984

Discussion

Consultation rates for children in general practice are higher than for other age groups (spart from very old people). A small precent of the property of the prop

We acknowledge the support and advice of Professor J D E Knox and Mrs Christine Mason, and the statistical advice of Mr S Ogston. This work was supported by a grant from the Health Series Research Committee of the Chief Scientist Organisation, Scottish Home and Health Department.

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