

Editorial

Dr Mark Lev
Editor, GPIA

This first issue of the journal for 2001, includes a selection of original papers as well as a new News Section with information from the International Primary Care Respiratory Group (p 13) and its aim to focus upon Chronic Obstructive Pulmonary disease (COPD).

While more general practitioners are using spirometry in their day to day practice, the quality of readings obtained and the ability of individual practitioners is variable. Schermer et al (p 4-7) investigate whether subjects (inexperienced practice assistant who perform lung function tests in Holland) achieve better results if they could see the flow/volume curves in real time. While Peak Flow Rates were statistically significantly better, this was not so in the case of FE₁/FVC. Nevertheless, on the basis of moderate differences in readings achieved by assistants who could see the curves during the procedure the authors have recommended the use of spirometer with visible real time flow volume curves. Further study in this area is clearly needed. Their table (p 5) derived from the ERS and ATS guidelines is particularly helpful and could be used as a guide for practitioners in instructing patients how to perform spirometry.

It is often very difficult for clinicians to decide which inhaler device to prescribe. The paper by Allen et al (p 8-11) determined adult patients' acceptability of

the Salbutamol Clickhale[®] in routine clinical use. The study compared patients and physicians perceptions regarding three types of devices. The methodology and principles raised in this paper have general relevance to clinicians when deciding upon an inhaler device, and more importantly in reassessing patient once they have been prescribed a device.

Sheikh and Cook, in the fifth of their series of statistical notes (p 15-16), unravel some of the mysteries of sample size calculations for research, and offer some useful practical advice on the subject.

The GPIAG Registrar Audit Competition 2001 is announced on page 12. This carries a prize of £40 and an invitation to the winner to present their work at the GPIAG Annual Conference. It gives us pleasure to publish the paper by Dr Nicola Harker (p 17-18), the winner of the 2000 competition, on a practice audit to determine the level of entry of parents smoking status in their children's medical histories.

I would like to draw readers attention to the call for papers for our congress to be held in Manchester in September (see page 17). ■

Mark L Levy
Editor

What's New at the GPIAG

Dr John Haughne
Vice Chairman, GPIA

The New Year has heralded massive change at the GPIAG.

From 1st January 2001 we have shed our single sponsor status. We are truly grateful to Allen Hanburys for their practical and financial support over the years. Thanks to their nurturing we have matured into a healthy independent organisation, positioned with many benefits but increased responsibilities.

Over the last few months, we have addressed many of the fundamental business issues. Perhaps our most important and productive decision was to appoint Siân Williams as our part-time transition consultant. Siân has experience in public sector management and organisational development, education and the public health.

The process of identifying a part-time, permanent Director is underway; we hope to have the position filled for 1st July 2001. Full details are advertised in

this edition of *The Journal* (page 19).

We now have in place, or in late development

- an informal, structured business plan
- financial and accountancy systems that reflect our new status
- proposed amendments to the constitution for scrutiny at the annual meeting
- support from six pharmaceutical companies namely: 3M, AstraZeneca, Boehringer Ingelheim, MSD, Novartis and Schering Plough

The activities of the Group have been divided in a more formal manner than before.

The publication division will continue to be headed by Mark Levy, leading an influential and increasingly international editorial board.

Professor David Price, the GPIAG Professor of Respiratory Medicine in Primary Care, University of Aberdeen, has appointed a number of additional staff to his department. This unit forms the centre of

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Research network working for and with the GPIAG membership. Formal research arrangements and contacts are emerging both within the UK and beyond.

Kevin Gruffydd-Jones, Hilary Pinnock and Vincen McGovern are assessing the needs of Primary Care clinicians who wish to develop their expertise in managing respiratory illness. We then plan to address these needs by supplying educational resources of the highest standard. The composition of this group is under development. We would like to invite any GP with an educational or academic interest who would like to be involved, to please contact the GPIAG secretary.

We intend to join with the National Asthma Campaign, the British Thoracic Society and other to promote an effective, multi-agency external relationship policy. The aim of this association is to lobby at go-

vernment and senior NHS levels for adequate resource and a higher priority for strategies to deal with respiratory diseases

At an international level, the inauguration of the International Primary Care Respiratory Group (*Prim Care Resp J* 2000;9(2)) has our full support, and in fact our Primary Care Respiratory Journal will be their official journal. Increasingly, we can be involved in global activities paralleling our own in the UK

So what's not new at the GPIAG? Our core values remain "a commitment to improve patient care by promoting education, research and sharing of best practice in UK primary care". And a restated desire to communicate better with members and to involve them actively in the Group's activities. More than ever we need, and are grateful for, our members support. ■

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Feedback information from flow volume curves to the practice assistant improves spirometry test quality in general practice

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ABSTRACT

Objective To investigate whether the use of feedback information provided by viewing flow volume (F/V) curves during spirometry performed by practice assistants improves spirometry test quality

Methods Randomised controlled single session crossover study. Eight practice assistants performed spirometry in healthy subjects ($n=47$). Two measurement conditions were applied, one allowing viewing of F/V curves during the tests ('unblinded') the other not ('blinded'). Outcome measures were differences in FE₁, FVC, FE₁/FVC ratio, PEF, FE₁ repeatability and number of manoeuvres per test. Two lung function technicians indicated their preference for either the blinded or unblinded F/V curve

Results Higher PEF values were observed for the unblinded condition (0.43 L/s, 95% CI 0.08, 0.77). The other outcomes showed no differences. On average, one lung function technician judged that in 62% ($p=0.012$) of the pairs the F/V curve from the unblinded condition was better, the other technician judged so in 51% ($p=0.349$)

Conclusion: This study in healthy subjects shows that the use of information from F/V curves leads to a modest quality improvement of spirometry tests performed by practice assistants and can therefore be recommended for use in general practice

INTRODUCTION

The use of spirometry is rapidly increasing within primary health care in many developed countries. International practice guidelines on lung function measurement stress the importance of standardisation

of measurement conditions during spirometry.¹ These guidelines underline the value flow volume (F/V) curves may have in optimising spirometry test quality. Most modern spirometers display real-time F/V or volume-time curves during forced breathing manoeuvres. However, apart from one single observational study,² we could find no evidence for the assumption that providing technicians with feedback information from F/V curves contributes to the overall quality of forced breathing manoeuvres including spirometry testing.

If information from the F/V curve does indeed optimise quality of spirometry, ample attention on how to judge curves is appropriate for primary care professionals, since sufficient test quality is not always guaranteed there.⁴

The objective of the study reported in this paper was to investigate the added value of information obtained from viewing F/V curves on the quality of spirometry tests performed by sufficiently trained practice assistants. The study focused on the performance of the practice assistant. In Dutch general practice this is the paramedical discipline that has been trained for administrative and patient care related activities

METHOD

Design
The study was designed as a randomised controlled single session crossover study. In order to assess the feedback value of F/V curves during spirometry performance by practice assistants, two measurement conditions were created, one with and one without feedback information to the practice assistant. Of each study subject a pair of F/V curves – consisting of the 'best' manoeuvre of both conditions – was judged by two experienced lung function technicians with special