III
THE COMPLETION AND ANALYSIS OF WEEKLY RETURNS

The data required for the weekly returns are simply abstracted from the relevant loose-leaf sheets of the "E" book by the doctor or his secretary, on the day after the end of the " recording week ". The completed returns are sent to the Records Unit and the consolidated results can be made available two days after the end of the week to which they relate. An example of the weekly consolidated return which has been used is given in table V and a more detailed analysis could of course be produced if the numbers justified it. It should be possible to print in a standard form each week's results within 7 days, i.e., at least one week earlier than disease notifications are currently published in the medical press.

At present the number of recorders is very small, but it could be doubled immediately and quadrupled without much difficulty. During this phase of expansion every effort will be made to obtain a sample of practices representative of the country as a whole, at least with respect to regional representation and urban/rural division.

Detailed analysis of the data gives rise to considerable weekly fluctuation, due to the small numbers involved. This will be reduced as the number of recorders is increased, although, even with more recorders, weekly analysis will obviously be unprofitable for the rarer conditions listed.

The raw data can be related to the known population at risk, and age and sex specific rates can also be calculated. The crude rates per 100,000 population for several common conditions diagnosed during a 13 week period have been calculated and five of these are given in the table below. The corresponding rates obtained by dividing the figures published in the *British Medical Journal* by the population of England and Wales are also given.

TABLE V

RATES PER 100,000 POPULATION FOR A 13-WEEK PERIOD

	Notifications	Weekly returns
Dysentery	22·1	51·6
Measles	241·5	303·9
Pneumonia	10·3	235·5
Scarlet fever	9·7	9·7
Whooping cough	5·5	9·7

The higher rates derived from the weekly returns are to be expected and the differentials reflect the varying extent to which notifications are underscored for different diseases, i.e., a high standard of notifica-
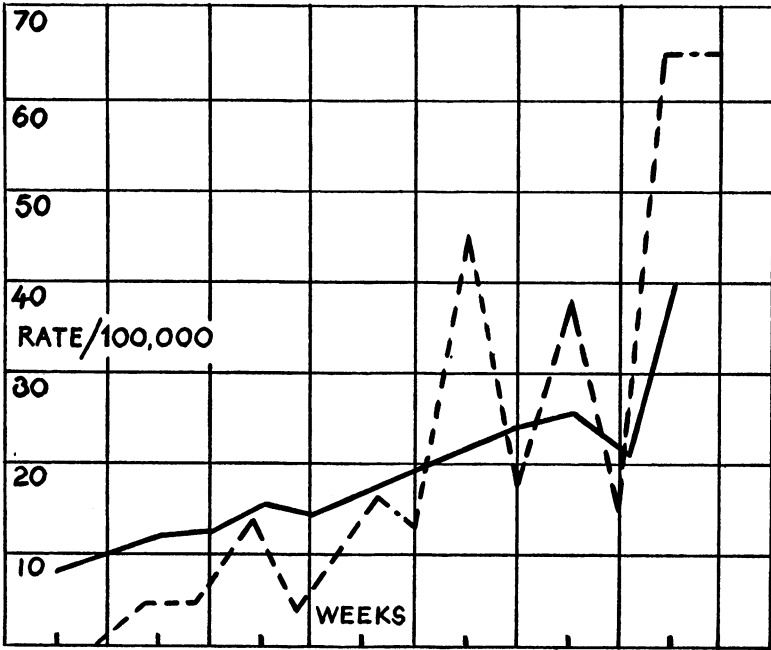
Figure 1.   Rates/100,000 for Measles, weekly
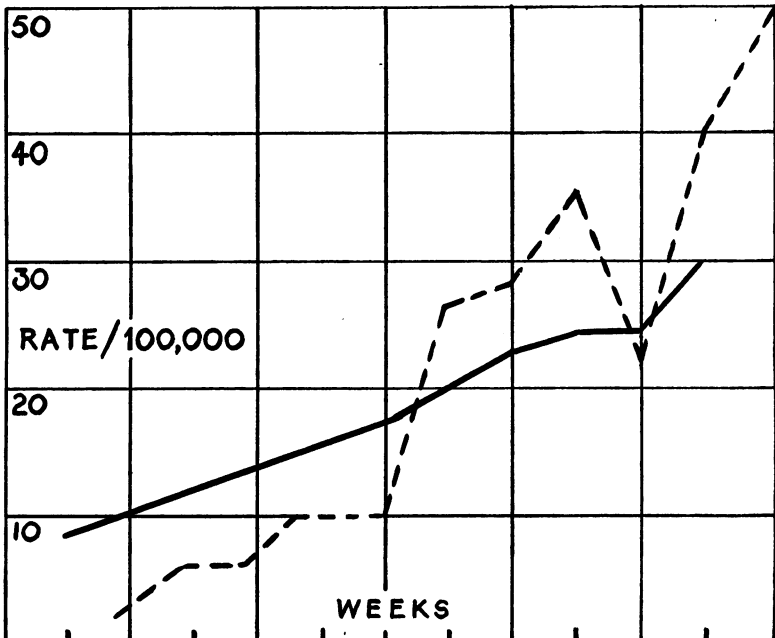Notifications, from 6 October, 1962— Weekly returns, from 11 October, 1962 - - -

Figure 2.   Rates/100,000 for Measles, weekly   3-week moving average

tion of highly infectious diseases such as scarlet fever and measles and a low level of notification in the case of pneumonia.

Finally a comparison of weekly notification rates (calculated on the same population) and weekly return rates for measles are shown diagramatically in figures 1 and 2. The weekly return rates are subject to a greater weekly variation but the trends in the two series are the same.

It is realized that our analyses, based upon reports from a limited number of observers, cannot be expanded indefinitely. For rarer diseases, material derived from existing sources, such as that published in the *British Medical Journal*, will remain our chief source of accurate information.

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IV

CONTINUED MORBIDITY RECORDING IN PRACTICE

The many practical difficulties facing an observer who wishes to study the illnesses which he encounters in practice have had a deterrent effect on general-practitioner research of many kinds. In the past consultations and visits to sick people were not generally recognized as potential units for the measurement of illness, and the item of service was not used as the denominator in epidemiological