PRACTICE OBSERVED

Practice Research

Why patient participation groups stop functioning: general practitioners' viewpoint

RICHARD G MANN

Abstract

Out of the 67 patient participation groups that were known to the National Association for Patient Participation as having been established by the end of 1983, 17 (25%) are not functioning. The general practitioners concerned with these non-functioning groups were interviewed to identify problems that they had had in keeping the group going and to seek possible explanations for the problems. Fourteen of the groups had stopped functioning in part owing to lack of interest by patients. Groups become non-functioning often in the first year of starting up, and this may be because of the nature of the practice population that they seek to represent.

Introduction

The first patient participation groups were established about 1973 in new health centres in Aberdare, south Wales; Berinsfield, Oxon; and Bristol. Since then 67 groups have been started. There are approximately 9000 practices in Britain, and so these groups represent roughly one in 135 practices. Growth in the number of groups starting up has been slow and some groups have stopped functioning.

This study aimed at describing the development of the patient participation group movement, with special reference to groups that have stopped functioning, and determining why some have stopped functioning by relating their experience to that of matched groups that are functioning. These questions have not been investigated previously, and the fact that there are non-functioning groups has been referred to only once.[1]

Department of Community Health, University of Nottingham, Queen's Medical Centre, Nottingham NG7 2UH
RICHARD G MANN, MB(BSC), medical student

Definitions

A "functioning group" is one where the committee holds regular meetings regardless of how often the group meets and so the group's activities continue to be organised. The purpose or function of the group—to provide feedback between doctors and their patients outside the consulting room—is maintained.

A "non-functioning group" normally means one where meetings have been suspended and the committee disbanded. In four groups, however, although committee meetings have been suspended and thus the group's basic function has stopped, there is a chance that the same committee will try to regenerate the group. Because there are no apparent differences in the experience of these four and other "non-functioning" groups they are included in this category.

Though a group may no longer function in a practice, the concept of patient participation and notions of starting a new group usually linger, both legacies of a previous group.

Method

A brief questionnaire was mailed to each general practitioner whose name was listed beside the 54 groups in the *1983 Directory of Patient Participation Groups* (National Association for Patient Participation). This identified groups that had stopped functioning since being listed. Those that had stopped functioning before the directory was compiled were notified to me by the association. Forty four (81%) questionnaires were returned. Follow up was successful so that the status and lifespan of every group known to the association up to the end of 1983 was established.

All non-functioning groups identified were eligible for inclusion in a survey by interview, which was designed to outline similarities

Discussion

The experience of patient participation groups that have stopped functioning has not been reported before. It is hoped that by reporting these findings there may be a better understanding of the practicalities and possibilities for groups to continue. It is unrealistic to hope that every practice might incorporate a patient participation group. Many groups have stopped functioning, and there is evidence that however well organised they are the practice setting is crucial to their survival.

Though groups stop functioning for many reasons, lack of patient interest was thought to be the fundamental problem. Unless patients participate in sufficient numbers groups are not representative of "their" practice population. They also depend on a few enthusiastic people and thus are vulnerable when these people are unavailable or lose their motivation. Wood also saw lack of interest as the major barrier to the growth of the patient participation movement.[2] She believes, however, that until all efforts are made to advertise the existence of groups, within the awkward guidelines of the BMA's Central Ethical Committee, this cannot be interpreted as signifying a lack of need.[3]

Perhaps before trying to start a group the organisers should ask patients: "Do you want and will you support a patient participation group?" Furthermore, after the group has started patients could be asked: "Is the group developing as you wish?" This might help groups to negotiate the regular stumbling blocks identified in this study.

Whatever the future of the patient participation movement is, clearly such groups are not *the* answer to obtaining patient participation in general practice, however attractive they are in theory.

I thank Dr Mike Sheldon, my tutor, for his guidance; Mrs Joan Mant and Dr Tim Paine of the National Association for Patient Participation for their help and enthusiasm; and King Edward's Hospital Fund for London for a grant.

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ONE HUNDRED YEARS AGO

As I foreboded in my last letter, Dr. Sandwich has been obliged to resign his appointment of Subdirector of the Egyptian Sanitary Service. Pressure was brought to bear upon him hugely to his pecuniary detriment, by throwing in the way of every administrative action which he undertook, so that he found it useless to retain his post. He will remain in Cairo, and continue his private practice. He has been succeeded by Surgeon-Major H. R. Greene, who has had considerable experience in sanitary administration in India and elsewhere. He came from Wady Halfa to take his new appointment. Surgeon-Major Greene has a good knowledge of written Arabic, which he will find invaluable in the difficult post on which he has just entered. No other changes in the *personnel* of the service have yet been made, but there will probably be some before very long. It is indeed reported that Ismail Pasha Yousey is discontented with his new post of Director of the Service, and intends to leave it as soon as he can. Who will succeed him is mere matter of conjecture, but it is at least certain that there is no Egyptian suitable for the post. It may be questioned whether there is any need for two directors. Probably much more reform would be achieved if the English director were alone, but such a simple and inexpensive mode of administration cannot be hoped for under the present control. A commission is shortly to sit on the subject of drainage of Cairo. The difficult problem of what to do with the ancient and almost sacred "khalig" will be the primary subject of consideration. The khalig is a deep canal, dry in summer, which carries Nile water across the elevated part of Cairo during the inundation. It receives the drainage of the houses it passes in its course, and is, consequently, little better than an open, almost currentless, sewer. Its yearly cutting, at the rising of the Nile, is the subject of a popular festival, at which, for many centuries, a virgin victim used to be sacrificed. It has been proposed, on one hand, to cover it in, and, on the other, to keep it permanently dry, and convert it into a road. The former plan would be too expensive, and the latter would interfere with national prejudice. As regards the general question of removal of sewage, there is no doubt that no system of drainage will be successful, and that the system of dry removal is the only one suitable to the peculiar conditions of Cairo. The commission originates with the Department of Public Works, of which Colonel Moncrieff is head. Dr. Chaffey Bey and Mr. Hooker represent the Sanitary Service, a third member is a French engineer, and a fourth the subgovernor of Cairo. To the commission itself we can take no exception, but the question occurs, Will anything be done in consequence of it? Surgeon-Major Greene has a scheme for provoking all the provincial mosques with a double system of removal of sewage, the dry part being carried away to sewer-farms, the wet being allowed, as now, to sink into the ground, or run off into canals and pools. It is to be hoped that funds may be found for carrying out this and other reforms. Unfortunately, the surplus £10,000 which stood over from a previous year, and was to have been applied to reforms during this year, has been lost to the Sanitary Service through not having been appropriated before the close of last year. This is another illustration of the haphazard way in which Egypt is at present ruled. The new Victoria Hospital, supported by the communities of the four Protestant nations—England, Germany, Switzerland, and the United States—is completed, but has not yet been formally opened. It is nursed by the Kaiserswerth Protestant Sisterhood, which institution refuses to allow any but Protestants to be members of committee of the hospitals it takes in charge. By inadvertence, several Roman Catholics were appointed on the committee of the Victoria Hospital, and only recently did it become known that their appointment was against the rules. Although their retiring was not insisted on, much ill-feeling was aroused by the knowledge of the intolerant regulation. An amateur musical and operatic performance was about to be given at the time, and the proceeds were to have been devoted to the Victoria Hospital; but, on account of this unfortunate misunderstanding, they were diverted to the native hospital. The performance was very successful, and it is expected that more than £500 will be handed over the Kasr-el-din Hospital. Mr. Milton, the resident medical officer, recently performed ovariotomy at this hospital. The operation was done under full antiseptic precautions, and appeared to be wholly successful. The patient rallied, and was doing well for two or three days, when she unexpectedly died. *Post mortem*, all the parts involved by the wound were found to be doing well; but a nest of lumbricoid worms was found in another part of the peritoneal cavity, which had set up peritonitis, from which, presumably, the patient died. No aperture was found through which the worms might have performed the bowel. Dr. Farquharson, M.P., has been visiting Egypt for the last three or four weeks. He will reach England in time for the opening of Parliament. He will have much to tell the government of the sanitary requirements of this country. (*British Medical Journal* 1885;i:401.)

Dr. Norman Moore, who has already discussed, with great skill, the question of the true cause of death of several historical characters, has communicated to the *Athenæum* of January 31st, his opinion on the alleged death, by slow poisoning, of Queen Catherine of Aragon. Contemporary historians believe that that pious and unfortunate princess really died by foul means; but Dr. Moore points out that the embalmer of her corpse made the following note. "He had found all the internal organs as healthy and normal as possible, with the exception of the heart, which was quite black and hideous to look at. He washed it, but it did not change colour, then he cut it open, and the inside was the same. Moreover, a black round body stuck to the outside of the heart." Comparing this description with a specimen of melanotic sarcoma of the heart in the Museum of St. Bartholomew's Hospital, Dr. Moore considers that it tallies with what any man ignorant of that disease might write, if called upon to describe an actual specimen. Though there is a tendency, even now, amongst the inexperienced to call anything in a sick man or in a corpse "black" that is darker than usual, it must be admitted that the "black round body" is very suggestive, and the symptoms of the royal patient also support Dr. Moore's theory, that she died of melanotic sarcoma. It has been suggested in a later number of the same periodical that Dr. Moore may have been perfectly correct as to his surmise of the existence of melanotic sarcoma, but that the Queen's death was, at least, hastened by ill-usage. (*British Medical Journal* 1885;i:393.)

and differences in the structure and problems experienced by the two types of groups. The interview was piloted with a group practice in Collingham, Nottinghamshire.

I interviewed personally or by telephone 13 general practitioners who represented non-functioning groups, using an interview schedule that I had designed. A further 13 general practitioners who represented groups that were functioning were also interviewed for comparison. These were selected by matching, so far as choice permitted, according to age of group, geographical proximity, and type of practice. Matching groups controlled for certain extraneous variables, enabling a more accurate comparison to be made of the structure of paired groups. General practitioners, however, made casual observations about the way factors other than how the groups were formed had affected their operation. Four non-functioning groups were omitted from this survey: two were never truly established and two could not be adequately paired with a functioning group. Nevertheless, the main problems and the lifespans of these groups were known and incorporated into the results.

For statistical analysis the Fisher exact probability test was used. A guarantee of confidentiality was given, so individual groups cannot be identified in this paper.

Results

The table shows that up to the end of 1983 a total of 67 groups with 200 group years of experience were known to the national association. Fifty groups still function, but according to the definitions in this study 17 (25% of total) are not functioning. Despite the number of groups that stop functioning each year the patient participation movement continues to grow in real terms at a rate of 10% in 1983.

Development of patient participation groups from 1972 to end of 1983

	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983
Total No of groups formed	1	2	3	6	9	13	23	30	37	47	53	67
No of existing groups	1	2	3	6	9	13	23	30	35	40	43	50
No of new groups	1	1	1	3	3	4	10	7	7	10	6	14
No of non-functioning groups*	0	0	0	0	0	0	0	0	2	5	3	7

*A total of 17 by the end of 1983.

Since each group is tailored to the local needs of the patients in the practice whom it seeks to represent groups inevitably show a range of interests. Some similarities emerged, however, from the 26 groups that I studied. Over half of the groups were associated with health centres (n = 22) and with teaching practices (n = 15). Roughly half of each type of group were formed solely because the idea of patient participation appealed, and 85% (n = 11) of each type were initiated by a general practitioner.

WHY GROUPS BECOME NON-FUNCTIONING

General practitioners who were associated with 14 of the 17 non-functioning groups stated that in part the demise of the group was due to lack of patient interest. One doctor described "an element of sheer apathy." When groups start up interest is usually strong and a committee of active patients is formed. Subsequently, interest lapses and, unless this is halted, even the active patients disappear.

Several doctors suggested what the cause of the lack of interest in their groups was. One thought that in his inner city practice, which was made up of a mobile population with a large ethnic component, there was "no natural community a group could represent." Another thought that because the patients were predominantly working class they were "not used to taking control of their lives" in the way that membership of a patient participation group requires and so did not participate. In another practice a large proportion of the patients were young married couples with children, who have little time to spare for a group. Rather than blame the patients, however, another doctor blamed the group, believing "patient numbers were low due to a failure of planning—we lacked the necessary organisation."

What may happen, though, is that groups maintain sufficient interest for many years and then reach a stage when they have talked through all the immediate problems. For instance, in one group "the teething problems of the new health centre have been overcome, hence little work for the group." In such cases groups should generate a new initiative rather than disband, particularly when, in this case, they have worked over seven years to become integrated into the health centre. Some functional groups have successfully negotiated such problems.

The committee is a vital component of any group and six doctors recorded problems in this area. One committee "lacked the necessary motivation," possibly because those who participated, unlike "middle classes and union members," were "unused to committee work." Another "lacked a clear leader and task, which led to dissension." As happened in another group, this may have caused meetings to be destructive, which "doesn't provide any longterm motivation." One group was distracted early on when it failed to elect officers, and another group failed to elect a new committee at the last meeting.

Other problems included overdependence on a doctor or patient (four groups), the doctor attempting to withdraw his support in the interests of group autonomy, and a group collapsing "after three years due to a committee which left all the work to the secretary who (through illness) couldn't continue." And a cautionary tale unfolded: a group was started because of a move to a new health centre, which was located in the grounds of a small district hospital, so it failed to define any useful improvement in health centre facilities or to justify its existence.

WHEN DO GROUPS BECOME NON-FUNCTIONING?

Groups become non-functioning most often within one year and between four and five years after they are started. General practitioners were asked, "Do you think there is a problem period in the life of groups?" Most said yes, but only those with non-functioning groups offered an explanation. In the first year "the novelty fades like anything new." For groups that folded at the later stage general practitioners said that "after a time groups tend to stagnate, finding it hard to recruit new people," or alternatively they can go "full circle" and actually "run out of things to do." By contrast, some doctors with groups that were functioning chose not to identify a particular problem period but believed, for example, that "you've got to keep working at any group."

ARE CERTAIN GROUPS PRONE TO STOP FUNCTIONING?

The problems encountered by the 13 functioning and the 13 non-functioning groups were similar: lack of patient interest, seven and five groups respectively; committee breakdown, one and four; combinations of the above, one and three; other problems, four and one. Certain underlying differences emerged, however. Average attendance at open meetings during the life of groups that stopped functioning was 14·8 people, whereas the functional groups averaged 36 people. This difference was statistically significant. Of the functioning groups, five had an average of 0-15 participants at open meetings and eight groups had from 16 to 100. Of the non-functioning groups, 11 had had an average of 0-15 participants and two groups had had more than 15. Non-functioning groups may not have had much community support and thus been vulnerable to lapse of interest.

The committees of non-functioning groups were more often described as inadequate (nine) than were those of functioning groups (two). Of the functioning groups, 39% reported meeting all their goals. No non-functioning group reported doing so, suggesting that it is important for groups to set themselves appropriate targets for activities.

Lifestyle assessment: applying microcomputers in family practice

H A SKINNER, B A ALLEN, M C McINTOSH, W H PALMER

Abstract

A randomised trial of assessment by computer was conducted with 180 patients in a family practice clinic. Histories of alcohol, tobacco, and drug use were obtained by computer (n = 60), interview (n = 60), or self completed questionnaire (n = 60). The results of previous research suggest that some patients may provide more accurate information about "sensitive" problems to a computer. No significant differences, however, in levels of consumption or problems were reported for the three methods of assessment. Patients gave differential ratings about the method of assessment, with the computer rated as more interesting but also more mechanical, cold, and impersonal. Although the interview was initially preferred by most, patients who completed the assessment by computer showed a significant increase (13% to 43%) in their preference for the computer after the assessment. The results of our study indicate that patients' acceptance of computers in family practice may be favourably influenced by direct experience with a microcomputer.

Introduction

Computers offer considerable potential for helping the busy family practitioner.[1 2] The availability of low cost but powerful microcomputers has been accompanied by a proliferation of software packages for virtually every aspect of office administration and patient care.[3] Despite this promise there are snags with respect to performance of equipment, costs of implementing it, and acceptance by staff.[4 5] Both doctors and patients have had misgivings about the use of computers in general practice.[6 7]

We examined the application of microcomputers to the assessment of lifestyle with patients who visited their family doctor. Our main objective was to evaluate the acceptance by patients of assessment by computer. Also, encouraged by suggestions that some patients may provide more accurate information about "sensitive" problems to a computer,[11 12] our second objective was to determine whether patients would tell more about their use of tobacco, and drugs to a computer than in an interview or on a self completed questionnaire.

Methods

Our sample was 180 outpatients at the Family Practice Service affiliated with Toronto General Hospital. This group practice with 12 family doctors has roughly 2500 patient consultations a month. Consecutive patients 18 years or older who visited were asked to participate in a study comparing different methods for obtaining information about their use of alcohol, tobacco, and drugs. Seventy seven per cent of the patients who were approached agreed (9% were excluded because of difficulty with the English language; and 14% were not feeling well enough, did not have enough time, or were not interested). Three quarters were assessed before their appointment with the doctor. Over two thirds of patients had consulted the doctor previously. The mean (SD) age of patients was 36 (14) years. There were slightly more women than men, and nearly half of the patients were single. Nearly half had had some education past secondary school.

Lifestyle questionnaire—This briefly assesses the use of alcohol, tobacco, caffeine, medications, and non-medical drugs. (A copy may be obtained from HAS.) The questions were taken from several

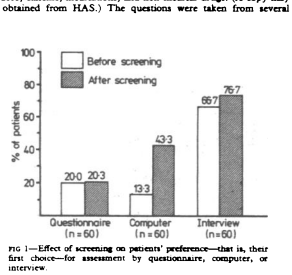

FIG 1—Effect of screening on patients' preferences—that is, their first choice—for assessment by questionnaire, computer, or interview.

sources, including our previous study,[13] the Health of Canadians survey,[14] and two screening instruments (MAST[15] and CAGE[16]) that are often used to detect drinking problems.[14–16] It took roughly 10 minutes to administer.

Rating of the method of assessment—Patients ranked their preference for the three methods (interview by computer, self completed questionnaire, face to face interview) both before and after they completed the lifestyle questionnaire. Also, their perception of the assessment experience was measured using a 16 item semantic differential rating on a five point scale. The specific adjective pairs were drawn from the three factors of evaluation (pleasant-unpleasant); potency (easy-hard), and activity (fast-slow).

Patients were randomly assigned to one of three methods, which were administered in private rooms at the clinic. Three patients out of 63 who were assigned refused to participate in the assessment by computer, and two patients of 62 assigned withdrew from the study during the face to face interview. All patients assigned to the assessment by questionnaire completed the assessment. The final groups were balanced in size: computer 60, interview 60, questionnaire 60.

The face to face interview was conducted by specially trained research assistants who asked questions from the lifestyle questionnaire in a straightforward manner without excessive probing or supportive counselling. Patients were given instructions for answering the lifestyle questionnaire and completed it in private. The computer interview was conducted using the IBM Personal Computer. After a brief introduction to the microcomputer patients answered three sample questions at the keyboard to familiarise themselves with the

Clinical Institute, Addiction Research Foundation and Department of Family and Community Medicine, Toronto General Hospital, Toronto, Canada
H A SKINNER, PHD, senior scientist and associate professor
B A ALLEN, MA, research associate
M C McINTOSH, MD, head of family and community medicine
W H PALMER, MD, FRCPC, professor and family physician-in-chief

Correspondence and requests for reprints to: Dr Harvey A Skinner, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Reasons given by patients for liking or disliking assessment by interview, questionnaire, and computer

Like	Dislike
Interview	
"I like talking to people"	"Too personal; possibility of contact"
"Allows both parties to understand the question"	"Not as much time for thinking or changing mind"
"It's a more honest way of dealing with human beings"	"Awareness of interviewer's reaction to responses"
Questionnaire	
"More impersonal"	"Too impersonal"
"Can set my own speed"	"Hard to interpret questions sometimes"
"Less chance for embarrassment"	"Poor handwriting or spelling"
"Time to think over the question"	
Computer	
"Think it would be interesting"	"Frightening. Information can be called on by anyone for malicious use"
"Have never tried it"	"It's a machine and I would feel stupid talking to machine"
"Fast, private"	"I loathe technology"
"Tendency to be more honest"	"Computers take away employment"

technique, and then they completed the lifestyle questionnaire in private. All items were shown on the computer's video screen and were answered by entering an appropriate number on the keyboard. After completing the lifestyle questionnaire feedback was given on important findings in a similar fashion for each assessment condition. Patients also evaluated their assessment condition using the semantic differential scale which was self completed.

Statistical analyses were conducted using the SPSS software package.[14] Items from the lifestyle questionnaire were grouped to form indices of problem recognition, frequency, and quantity of consumption. Multivariate analysis of variance was used to test the hypothesis of differences in reporting across the three methods of assessment (computer *v* questionnaire *v* interview).[15] Separate analyses were conducted within each of alcohol, tobacco, caffeine, and non-medical drug use.

Results

Patients visited their doctor with a broad range of disorders. The most frequent ICD-9 (International Classification of Diseases) diagnoses related to problems with the musculoskeletal system (18%), examinations of state of health (14%), mental disorders (12%), and digestive (11%), circulatory (10%), and genitourinary (10%) disorders. Eighty six per cent of patients consumed alcoholic beverages, 35% smoked cigarettes, 87% consumed coffee or tea, and 20% reported some non-medical drug use. Over half reported no previous experience with computers or computer games.

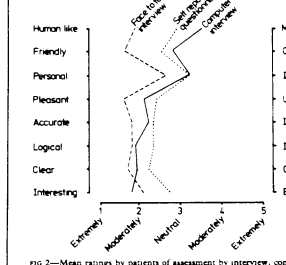

FIG 2—Mean ratings by patients of assessment by interview, computer, and questionnaire

Before the lifestyle assessment began patients were asked to rate their preferred method of assessment. Most ranked a face to face interview as first choice, whereas a fifth preferred a self administered questionnaire, and even fewer selected a computer. After completing the lifestyle assessment patients were again asked their preferences. For those patients who were assessed by interview and questionnaire there was no change (fig 1). There was, however, a threefold increase ($p < 0.001$, χ^2 test) in the preference for the computer by patients who were assessed by computer (fig 1). This increase was more pronounced for patients who had had no previous experience with computers (47% selected computer as first choice) than for those who had had some experience (39% selected computer as first choice). The table gives some of the reasons for their preferences. A tendency to like or dislike assessment by computer was not related to the patient's age, sex, marital state, or education or occupational level ($p > 0.05$ for all correlations).

Statistically significant ($p < 0.05$) differences (ANOVA) were found on eight semantic differential ratings (fig 2). The interview was most favoured on all dimensions, with the one exception that the computer was rated as the most interesting. In general, all three methods were rated toward the favourable end of each dimension.

Figure 3 compares patterns of consumption reported for the three methods of assessment. There were no significant differences in these comparisons, or in more detailed multivariate analyses conducted separately within alcohol, tobacco, caffeine, medication, and drug use.

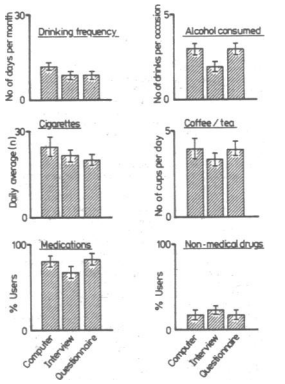

FIG 3—Mean consumption patterns elicited by three assessments (computer (C), interview (I), and questionnaire (Q)). Bars represent SEM. The data on alcohol and cigarettes exclude abstainers

Discussion

The most important finding from this study was that undergoing assessment by computer positively influenced patients' preference for it, whereas there was no change in preference for either the interview or the questionnaire. By inference, acceptance by patients of computers in family practice should increase as they have experience with computers.[16] Some patients did, however, have negative attitudes about computers. Roughly 8·5% still disliked computers after their experience in this study. Also, at the beginning of the study participate in the study. Seventy seven per cent of patients who were asked agreed to the assessment; 9% were excluded because of difficulty with the English language; 14% were not feeling well enough, did not have enough time, or were not interested. Three quarters were assessed while waiting to see the doctor. Over two thirds of patients had consulted the doctor previously. Forty three per cent were men and 57% women; mean (SD) age was 36 (14). About half were single, most of the remainder were married, and a few were separated, divorced, or widowed. A quarter had had primary or some secondary education, a third had completed secondary school, and the remainder had completed community college or had a university degree, or both.

Lifestyle questionnaire—This briefly assesses the use of alcohol, tobacco, medication, caffeine, and non-medical drugs. The questions were adapted from a previous study[4] and from the Health of Canadians survey,[13] and included two screening instruments (the MAST[17] and CAGE[18]) that are widely used to detect alcoholism.[1 4 13] The lifestyle questionnaire took roughly 10 minutes to complete. Feedback was given on how the patient's consumption levels compared with those of others of the same sex and age. A copy of the lifestyle questionnaire may be obtained from HAS. This questionnaire is being expanded for future studies to include items relating to nutrition, exercise, sleep habits, and physical safety.

Doctor's form—The doctor recorded each patient's diagnoses according to the ICD-9 (International Classification of Diseases). The doctor also rated whether the presenting problem was related to alcohol, tobacco, or drug use, and whether the patient had a history of problems of abuse.

Results

Table I gives the disorders that were diagnosed. Table II summarises the history of the use of alcohol, cigarettes, caffeine, and drugs. Fourteen per cent of patients were diagnosed as having drinking problems using the CAGE questionnaire,[18] whereas the MAST indicated that only 3% had severe consequences from drinking that would indicate alcoholism.[13] Over two thirds of smokers considered that their smoking was a problem. Most patients regularly consumed coffee or tea, and over a third thought that they consumed too much. Most had taken some medication in the past two days, mostly vitamins or minerals and pain relievers. Roughly a fifth of patients admitted to using drugs (mainly cannabis) for non-medical purposes in the past year.

TABLE I—*Diagnoses for 180 patients*

Diagnosis and % of patients
Musculoskeletal: 710-739: 18
Health status V01-V82: 14
Mental disorders: 290-319: 12
Digestive: 520-579: 11
Circulatory: 390-459: 10
Genitourinary: 580-629: 10
Nervous, sense organs: 320-389: 8
Respiratory: 460-519: 6
Infectious, parasitic: 000-139: 2
Skin, subcutaneous: 680-709
Endocrine, nutritional, metabolic, immunity disorders: 240-279: 4
Blood: 280-289: 2
Complications of pregnancy: 630-676: 2
Ill defined conditions: 780-799: 2
Injury poisoning: 800-999: 1

Note: Numbers in parentheses are ICD-9 codes (International Classification of Diseases).

TABLE II—*History of use of alcohol, cigarettes, caffeine, and drugs for 180 patients*

	Alcohol (past 12 months)	Cigarettes (at present)	Coffee or tea (past 30 days)
Reported use (%)	86	35	87
Problem recognised (%):			
All patients	11	20	36
Users only	15	68	42
Mean (SD) daily consumption, regular users only	14·0 (22·7 g ethanol)	22·2 (10) cigarettes	4·2 (4·5) cups

	Medications (past two days)	Non-medical drug use (past 12 months)
Reported use (%)	77	20
Detailed breakdown, all patients	40 Vitamins or minerals 29 Pain relievers: aspirin: 14 14 Skin ointments 12 Tranquillisers 11 Heart/blood pressure medicine 11 Stomach remedies 7 Antibiotics 7 Cold remedies 3 Laxatives	18 Cannabis 6 Cocaine 6 Stimulants 3 Hallucinogens 2 Sedatives 1 Tranquillisers 1 Non-heroin opiates
Problem recognised (%):		
All patients	Not assessed	3
Users only	Not assessed	14

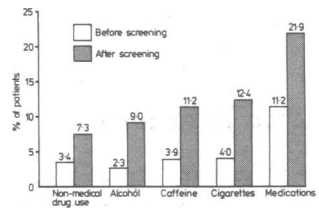

FIG 1—Impact of assessment on patients' intentions of discussing a problem of abuse with their physician

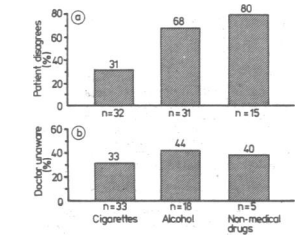

FIG 2—Disagreement between doctor and patient in rating a problem of abuse. (*a*) doctor indicates that the patient has a problem when the patient disagrees or denies it; (*b*) patient acknowledges a problem when the doctor did not indicate it.

One of the most important findings was the reaction that patients had to the assessment. They were asked if they had come to see their doctor with the intention of discussing a problem of abuse (fig 1), and on completing the lifestyle assessment and feedback on their results they were again asked if they intended to discuss a problem with the doctor. An appreciable increase ($p < 0.01$, χ^2 test) was evident across all classes of substances (fig 1). This was even more pronounced among the 135 patients who completed the lifestyle assessment before seeing their doctor that day (9% intended to discuss their non-medical drug use, 11% alcohol use, 13% caffeine use, 13% cigarettes, and 25% medication use).

Overall, there was a high level of agreement between the patient and doctor about the presence or absence of a problem with alcohol (79%), cigarette smoking (79%), and non-medical drug use (85%). In some instances, however, the doctor indicated a problem that the patient either disagreed with or denied (fig 2(*a*)). This disagreement was least evident for cigarette smoking and most prominent for

three patients refused to use the computer. Thus roughly 10-15% of patients had a negative reaction to assessment by computer. Cruickshank found that computers are least welcomed by highly stressed or nervous patients.[14] Such patients should have the option of being assessed by an interview or questionnaire.

Our findings reinforce previous work in not finding any significant differences among methods of assessment in reporting levels of consumption of alcohol, cigarettes, and drugs or related problems.[1 4] Thus deciding which method to use depends on which is most efficient for a particular practice. As low cost microcomputers and related software become more available assessment by computer is feasible in many practices. The computer also offers rapid scoring, immediate feedback, and individualised reports. On the other hand, an interview allows the doctor to obtain more in depth and personal knowledge of the patient. A skilled interviewer may be able to minimise deception with defensive patients and probe further with patients who lack insight or have difficulty reading and understanding the questions.

We suggest that a microcomputer should be considered when feasible for routine use in the assessment of lifestyle. The results may be reviewed briefly with the patient, and the doctor can reinforce healthy behaviour as a preventive measure. Such an assessment may also provide an efficient method for case finding in a busy practice.

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Lifestyle assessment: just asking makes a difference

H A SKINNER, B A ALLEN, M C McINTOSH, W H PALMER

Abstract

A 10 minute assessment of 180 family practice patients showed that 11% indicated a problem with drinking alcohol, 20% with cigarette smoking, 36% with consumption of coffee or tea, and 3% with non-medical drug use, while 11% wanted to discuss their use of medications. Moreover, being asked questions resulted in a twofold or threefold increase in the patients' intentions of discussing such a problem with their doctor. Although there was good overall agreement in recognising a problem between the patient and doctor, in roughly 40% of instances where the patient indicated a problem the doctor was unaware of it. These patients tended to be young, well educated, and employed in professional occupations, and were on their first visit to the doctor.

Such brief assessments of lifestyle should be routinely conducted in family practice for both case finding and prevention.

Clinical Institute, Addiction Research Foundation and Department of Family and Community Medicine, Toronto General Hospital, Toronto, Canada

H A SKINNER, PHD, senior scientist and associate professor
B A ALLEN, MA, research associate
M C McINTOSH, MD, head of family and community medicine
W H PALMER, MD, FRCPC, professor and family physician in charge

Correspondence and requests for reprints to: Dr Harvey A Skinner, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Introduction

Excessive alcohol consumption, cigarette smoking, and drug abuse are major health concerns in Western society and often pass unrecognised in hospitals and family practice.[1–4] The family doctor is in a good position to identify abuse when brief intervention may be effective.[4 5] Practical methods are needed to ensure that histories of use are routinely taken and that diagnostic tests are applied when appropriate.[4–6]

We evaluated the impact of assessing lifestyle on patients who visited their family doctor. Our objectives were: (*a*) to describe the extent of alcohol, tobacco, caffeine, and drug use among patients in family practice; (*b*) to determine whether routine assessment would increase the patients' intentions of discussing a problem of abuse with their doctor; and (*c*) to examine disagreements between the patient and doctor in recognising abuse.

Methods

Our sample was 180 outpatients from the Family Practice Service affiliated with Toronto General Hospital. This group practice with 12 family doctors has roughly 2500 patient consultations a month. Consecutive patients 18 years or older who visited were asked to

non-medical drugs. Patients who failed to acknowledge an alcohol problem tended to be middle aged (mean 41 years) men with less education (half had not completed secondary school), employed in unskilled occupations, and had seen the doctor before. By contrast, in under half of cases where the patient indicated a problem the doctor either did not rate a problem or was unaware of it (fig 2(*b*)). The doctor tended to fail to identify alcohol problems among younger patients (mean 34 years), who were better educated, employed in professional occupations, and were on the first visit to the doctor. Similarly, patients with smoking problems which the doctor failed to detect tended to be younger (mean 31 years), better educated, and female.

Discussion

Our findings show that a brief assessment of the use of alcohol, cigarettes, caffeine, and drugs is feasible in a busy practice, and that an appreciable number of patients may be identified who are concerned about their consumption. The lifestyle questionnaire may be administered in 10 minutes by a practice nurse, or it may be completed by patients while they wait to see the doctor, or it may be conducted efficiently using a microcomputer.[7–9]

The doctors in this study tended not to detect problems with new patients who had "positive" social characteristics—for example, young, better educated professionals. On the other hand, they were more likely to ascribe problems of abuse to patients with "negative" social characteristics—less education, unskilled occupations. This is consistent with the findings of other studies of patient characteristics that elicit negative reactions from doctors.[10–13] Although our findings are suggestive and need to be replicated, doctors' stereotypes of patients may hinder the detection of abuse.

Being asked questions resulted in a twofold or threefold increase in the patients' intentions of discussing abuse with the doctor. This "priming" effect was particularly evident among patients who underwent the lifestyle assessment before seeing their doctor. The results of other studies have shown that patients are often willing to talk about potentially "sensitive" problems, such as drinking habits, but not spontaneously.[1] Assessment of lifestyle and feedback encourages patients to think about their patterns of consumption and sets the stage for discussing them. This brief assessment, which may be routinely incorporated in family practice, may identify patients with unhealthy lifestyles.[1–13]

We thank the physicians and staff at the Family Practice Service of Toronto General Hospital for their assistance in conducting this study.

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100 YEARS AGO

Mr. W. S. Caine, M.P., Civil Lord of the Admiralty, recently speaking on the subject of the progress of temperance in the Navy, said it had been shown that the greatest hardships and the severest campaigns could be better carried out without the use of intoxicating drink than with it. Look, for example, at the present campaign up the Nile. The worst part of the desert route had now been traversed by the greater portion of Lord Wolseley's army, and it had been done upon water. The water, he regretted to say, was very indifferent in quality, being greatly diluted with mud, and was served out at the rate of one quart per man per day, but yet there had scarcely been an invalid. Then the most brilliant infantry charge of modern times—that of Tel-el-Kebir—had been carried through on cold tea, and not upon the spirit-ration. Every day it was proved that the finest service in the world—the men in the British Navy—could do all the work that fell to them better without than with intoxicating drink. He might instance the Marines working in the heat of Suakim and in the cold of Skye. As to the bluejackets, 8,000 of them were employed on shore, adding the four or five thousand abstainers in the naval schools and training-ships, the grand total of abstainers was 12,000. Intelligent officers knew how to value men who were abstainers, whatever might be their own views as to the matter of intoxicating drink. He could not but regard this as a most satisfactory condition of things, nor refrain from saying that the agency by which this had been brought about was that of the National Temperance League. They began with the lads in Greenwich Hospital School, where there was a flourishing Band of Hope. On entering the training-ships, they were encouraged to persevere; and finally, when drafted into the men-of-war, the temperance society established on board nearly each one of them was ready to receive them. For the first two years, they had cocoa and other things in lieu of the spirit-ration, which they, however, lost if at the end of that period they elected to have the spirit-ration. He was not in favour of compulsory temperance or of "stopping poor Jack's grog," as some had said, but of placing before the men of both services the argument for total abstinence, and allowing them to decide for themselves. At the late Scarborough election, the people were asked, "Will you vote for a man who is going to rob poor Jack of his grog?" and the answer of the electors was his return by a large majority. While he did not believe in compulsory temperance, still he would give the seaman every facility to be a total abstainer if such was his wish. *British Medical Journal* 1885;i:243.

The ukase of the General Medical Council, issued last October, laying down that all students, before being allowed to inscribe their names on the *Students' Register*, should exhibit a knowledge of the "elementary mechanics of solids and fluids, comprising the elements of statics, dynamics, and hydrostatics," has drawn forth from Trinity College, Dublin, a reply couched in somewhat sarcastic terms, and signed by Dr. Samuel Haughton. "The Provost and senior Fellows [we] having considered the matter for three months, express the "opinion that the knowledge of mechanics guaranteed by the examination proposed by the General Medical Council would not be worth possessing. The ideas involved in elementary mechanics, such as mass, inertia, velocity, momentum, vis viva, and energy, are difficult in themselves, outside the range of school-studies, acquired slowly even by those who alternately grasp them, and such that many highly educated men may pass their whole lives without once having had a clear conception of them." The University of Dublin has its own way of teaching elementary mechanics, and "the Provost and senior Fellows prefer this mode of teaching mechanics to that proposed by the General Medical Council, which, in their opinion, would be quite inadequate." Rebellion—flat rebellion! (*British Medical Journal* 1885;i:449.)