PRACTICE OBSERVED

Practice Research

Why patient participation groups stop functioning: general practitioners' viewpoint

RICHARD G MANN

Introduction

The first patient participation groups were established about 1973 in new health centres in Abecdare, south Wales, Berinsfield, Zoos; and Bristol. Since then of groups have been started. There are approximately 6000 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

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Method

A brief questionnaire was mailed to each general practitioner whose name was listed beside the 54 groups in the 1881 Directory of Patient Participation Crespo (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 operation of the stopped patient of the stopp

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

WHEN DO GROUPS BECOME NON-PUNCTIONING?

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

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

ck of need.*

Perhaps before trying to start a group the organisers should

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209-212

References

ONE HUNDRED YEARS AGO

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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 alcoho (bohacco, and the practice clinic districts) and the practice of alcoho (bohacco, and the practice) clinic properties of the practice of consumption or problems were reported for the three methods as assessment with the practice of the practice of

Introduction

Computers offer considerable potential for helping the busy family practitioner.* "The availability of low cost but powerful microcomputer has been accompanied by a proliferation of software packages for virtually every aspect of office administration and patient care." Despite this promise there are snage with respect to performance of equipment, costs of implementing it, and acceptance by staff." Both doctors and patients have had misgivings about the use of computers in general research."

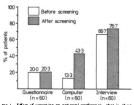
have had misgrangs about the use of computers in general pre-pre-tice.

The pre-tice of the pre-tice of the pre-tice of the sacessment of lifertyle with patients who visited their family doctor. Our main objective was to evaluate the acceptance by patients of assessment by computer. Also, encouraged by patients of assessment by computer. Also, encouraged by suggestions that some patients may provide more accurate information about "sensitive" problems to a computer," of the pre-tice of th

Our sample was 180 outpatients at the Family Practice Service affiliated with Toronto General Hospital. This group practice with

Clinical Institute, Addiction Research Foundation and Department of Family and Community Medicine, Toronto General Hospital, Toronto, Camping, Honor Kasenita and associate professor H A SKINNER, 1910, sensor kasenita and associate professor B AALLEN, Am., research associate M C MCNTOSH, AD, head of family and community medicine W H PALMER, Mo, PECC., professor and family phyricaio-in-chief

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In dividing our previous study, the Health of Canadians survey, that two screening instruments (MAST) and CAGE(that are often used to detect drinking problems. In the considerable of the control of the three methods (intervee) 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 intensured using a 10 terms enament differential raing three factors of evaluation (pleasant-unpleasant), potency (casy-hard), and activity (fast-low).

Patients were randomly assigned to one of three methods, which were administered in proset rooms at the clina. Three planets out computer, and two patients of 62 assigned withdrew from the study during the face to face intervew. All patients assigned to the assistment by questionnaire completed the assessment. The final groups were balanced in size computer 60, interview 60, questionnaire on the control of the