Such a reader will quickly appreciate a too-unhealthy reliance on the "tick box" type of questionnaire which reflects the mindset of those providing a service rather than that of those at the receiving end. This too often ignores two factors that bedevil virtually any attempt to find out what people really think about caring services. Firstly, there is the gratitude factor. People who think they are lucky to be getting a service at all or who perceive the caring staff as being overworked and underpaid, are often very reluctant to voice concerns they see as being beyond the control of the staff who look after them from day to day. Then there is the vulnerability factor. This comes out most clearly in the section devoted to the community health services. Users who are totally dependent on these for their continuing care and wellbeing, especially those in residential care, may be afraid to be critical.

The section on community care is particularly useful in that it goes beyond the practicalities of how to elicit users' and carers' views, and addresses the most effective ways of ensuring that they are actually involved in planning and evaluating future delivery of services.

Beginners start here, and I promise your learning curve will be reduced!

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An Analysis of Instruments and Tools used in Psychiatric Nursing Audit. Bond S, Balogh R, Simpson A, Quinn H, Dunn J, Wilkinson A, *et al.* (28 pp, £5). Newcastle upon Tyne: Centre for Health Services Research, 1993. ISBN 1-870399-56-0.

Despite the title this is not a report of great depth. Rather it is a "Cook's tour" of six (there are at least ten) audit systems used to appraise the quality of care in mental health. Four of the systems analysed are targeted at nursing, with the remaining two having a multidisciplinary focus. In the main the report consists of tables where each of the six systems are examined against a range of evaluative criteria. These include for each tool details of psychometric qualities, spheres of application, training requirements, data collection procedures, data sources, presentation of results, ownership of results, and how results are to be implemented.

At £5, the report may seem inexpensive, but with twenty eight pages (which I read in fifteen minutes) it is by no means a bulky tome. Furthermore, it does not provide an in depth exploration or discussion of each audit system nor does it inform readers which system is best for their care setting. In fact a caveat is inserted in the introduction explaining how, in the authors' opinion, it is the local circumstances that influence the adoption of an audit as much as the system itself.

After reading the body of the report I was looking forward to a concluding section of discursive text where the authors would pull together (and perhaps analyse!) the wide variations that exist between these audit systems. There isn't one; the report ends abruptly, and one is left with the impression that this analysis

was undertaken as an organisational checklist for a research literature review. However this does not mean that it is not a useful resource for those interested in audit. It does provide evaluative criteria which can usefully be applied to any audit tool. It also presents the beginnings of a conceptual framework which should support further discussions on audit.

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Change and Teamwork in Primary Care. Pringle M. (120 pp, £7.95). London: BMJ Publishing Group, 1993. ISBN 07279-0779-4.

General practice is now in a "managed health service." The changes in private industry are now being applied to public utilities like the NHS, and especially general practice. *Change and Teamwork in Primary Care* is a timely appraisal of the environment; it informs readers of the state of practice teams, where they have come from and where they may wish to go, but it does not guide them how they might get there. A valuable review of the current situation, it also flags up important issues. Its style is consistent and should be acceptable to members of the primary care team, which is a refocused group and an area of renewed interest for primary care managers; for both parties this book is essential background reading.

The book has two parts: managing change in general practice and partners in practice; the chapters have a user friendly format, aided by powerful drawings and clear summary boxes. Undoubtedly, people are a valuable resource, and the key message is that they and their skills be valued, but to deliver primary care in the future the competencies and training of general practitioners will also need to be reviewed. More could have been said in learning from the past about the individual in change, and how people may sometimes respond to change by elation followed by denial, burnout or by rationalisation and acceptance. There is a need for empathy with colleagues, to "walk in their shoes," as they will naturally ask what is in it for them and if the change is threatening will wish to maintain the status quo. In the chapter "strategies for success" I was hoping to read about a business plan and appraisal of strengths, weaknesses, opportunities, threats in general practice. Similarly, mapping the environment and reflecting on the external and internal environment was not mentioned. The key question is "What business are we in?"

Most people are clear on the need for change, and it was pleasing that leadership received due attention, with the visions of strong leaders such as Sir John Harvey-Jones documented. Visions, goals, and objectives are important targets. General practitioners should dream and share those dreams with their primary care teams. Little was said about education; hospitals and managers in the NHS have done better since 1985, with the NHS training agency, but we need better management, better health in primary care initiatives too.

The development of primary health care teams is well recorded. The work of the practice nurse is explained, but what about understanding the work of other primary care team members? If staff are properly trained and empowered there is a risk they may leave because of the limited ability in the NHS for financial reward. Recruitment and retention of key staff is therefore very important. Educational needs are important, but is there a robust method of identifying them and, more importantly, how are resources freed to meet them and from whom? Quality was mentioned throughout the book; why not involve some patients as non-executive members of the primary care team to ensure that the people who really matter are not forgotten?

For some people much in this book will be new. For others it may be a refresher, but they may be disappointed that the book does not go far enough. I believe the authors do not want to be prescriptive. That is good as it permits further ideas and thoughts. It's up to primary health care teams to find ways of making them a reality.

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Communication Audit Tools. Ambulatory Care Programme, Centre for Health Services Research. (74 pp, £12.00). Newcastle upon Tyne: Centre for Health Services Research. ISBN 1-870399-53-6.

An audit likely to yield useful results commonly develops from recognition of a problem in clinical practice. However, between that recognition and the final outline of an audit plan lies a vast amount of work including literature searches, consultation, negotiation, and consensus development about the exact nature of the problem, the data needed, and how the audit might be done.

Communication Audit Tools is a specific compilation of information and resources for audit of communications between hospital and general practice. A brief literature review and useful bibliography is followed by an overview of current interface audit activity, based on a survey of medical audit committees and medical audit advisory groups in Northern region, which may provide new ideas. On the basis of previous (referenced) work, the authors describe an audit tool which they have used to audit GP referral letters and consultants' replies. The method is described in detail for the administrative details (such as names, dates, and postcodes), which are obviously easier to score as present/absent, but the same methodology is also applied to the clinical content. Without actually piloting the tool it is difficult to know whether the clinical details can be so reliably scored in the same way, but the method seems simple, logical, and adaptable. The final section describes an (unreferenced) questionnaire which the authors have used to facilitate discussion between hospital staff and general practitioners about possible differences in their expectations. As part of that process it is likely to provide useful material, although it is not intended as an end in itself.

A criticism might be that this text does not contain information not available to interested readers from a literature survey and applying previously developed ideas, but it has the merit of containing diverse information in one place. It may therefore save time and provide a good basis for discussion and local negotiation about what your team wants to do. Particularly for audit staff whose task it may be to do preparatory work, it could be appealing. One dictionary meaning of a tool is "anything used as a means of achieving an end" – in this context *Communication Audit Tools* could indeed be useful.

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Making Medical Audit Effective. Joint Centre for Education in Medicine (192 pp, £8.99). London: Joint Centre for Education in Medicine. ISBN 1-873207-55-7.

Moving to Audit. Centre for Medical Education, Ninewells Hospital and Medical School, Dundee. (128 pp, £12.50; free to doctors in Scotland). Dundee: Ninewells Hospital. ISBN 1-871749-24-7.

Medical Audit Tools. Ambulatory Care Programme, Centre for Health Services Research (80 pp, £13.00). Newcastle upon Tyne: Centre for Health Services Research. ISBN 1-870399-42-0.

As a discipline medical audit is a metaphorical toddler and the emergence of reference texts is perhaps one of the signs of a developing maturity. Most of the skills necessary for audit are common to other disciplines: research methods, management of change, and team building, but it is useful to have some introduction to all this information brought together. Such texts are most likely to be valuable as reference sources to clinicians actively involved in their own audit, and they should also be useful to audit staff. They can provide a point of reference (not to speak unguardedly of a standard) for the different expectations which individuals or groups may have of audit, and they also have a role in defining agreed meanings.

"Outcome" is perhaps a good example, since at present, like Humpty Dumpty in *Alice in Wonderland*, it seems to mean what anyone chooses it to mean. Thus managers referring to bed occupancy rates or discharges as outcomes, clinicians referring to such things as wound infection rates, relief of symptoms, or readmissions; and audit staff getting quietly confused in the middle when the outcome of audit is mentioned are all using the same word in differing senses. Providing they realise this, there is no problem, but this may not always be so, and promoting the use of clearly defined terms is one of the tasks for the maturing toddler.

This same metaphor highlights a further problem, associated with the lag time involved in publishing, which means that

these texts refer exclusively to medical audit, at a time when the contribution of all clinical staff to patient care is increasingly realised as important. Of course, the concepts outlined apply equally to clinical audit, although the dynamics of group interactions assume even greater importance in clinical audit.

The material covered in the three texts differs in a few important aspects. *Moving to Audit* and *Medical Audit Tools* deal with the analysis and presentation of audit data in greater detail than *Making Medical Audit Effective*, which has a useful section on using audit for education and discusses the characteristics of the safe learning environment and adult learning patterns as well as the dynamics of small group work in some detail. *Medical Audit Tools* also discusses small group work in audit, based on the practical experiences of the authors. Managing change is dealt with well by *Making Medical Audit Effective* in a separate section, and it is a central recurring theme in *Moving to Audit*, with a useful list of references, which, generally, I have found more useful compared with those in the other texts.

Involving readers by suggesting tasks and activities which may be useful in developing audit skills, a feature of *Making Medical Audit Effective* and *Moving to Audit*, may help those previously uncommitted to get involved.

In summary, I would recommend *Moving to Audit* as the single most useful of the three, *Making Medical Audit Effective* has a strong claim on anyone particularly concerned with using audit as an educational tool. *Medical Audit Tools*, though less comprehensive, has important strengths as it draws heavily on practical experience developed during the North of England study of standards and performance in general practice; in that sense it complements the other basic texts.

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If you wish to order the titles reviewed or require further information, please contact BMJ Bookshop, PO Box 295, London WC1H 9JR (tel 071 383 6244; fax 071 383 6662). Books are supplied free of postage in the UK and to BFPO addresses; overseas customers should add 15% for postage and packing. Payment can be made by cheque in sterling drawn on a UK bank account or by credit card (Mastercard, Visa, or American Express) stating card number, expiry date, and full name. (The price and availability of titles are occasionally subject to revision by the publishers.)

MEETINGS REPORTS

Quality of care in family medicine/ general practice, WONCA/SIMG Congress, The Hague, Netherlands, June 1993

General practitioners in the Netherlands have taken the lead in the past ten years in introducing quality assurance into general

practice, showing how peer review involving groups of general practitioners can be effective in improving care and demonstrating how guidelines for care can be developed systematically and made available to the majority of general practitioners. All this has taken place with at least reasonable support from general practitioners themselves and without interference from central government. It was entirely appropriate therefore that this congress should, in part, celebrate the achievement of the profession in the Netherlands.

Jointly organised by WONCA (World Organisation of National Colleges and Academies of Family Practice) and SIMG (Societas Internationalis Medicinae Generalis), the congress attracted most participants from European countries. Large contingents were from the United Kingdom, Scandinavia, and many developed European countries excluding France, which only managed three representatives; several participants came from Canada, New Zealand, South Africa, and the United States. The programme was enormous, comprising hundreds of presentations, whose subjects ranged from women and fatigue, tests for hepatitis C, and assessment of communication skills to the impact of consensus recommendations for otitis media.

From this myriad emerged several themes related to quality of care. First was the role of guidelines, which formed part of the many reported projects, although the question of how effective they can be to bring about improvements in care was never fully resolved. Second was the assessment of outcome, with the variety of approaches including presentations about newly developed measurement instruments, theoretical discussions about the meaning of health outcome, and comparative studies of different methods such as the COOP charts, the SF-36 questionnaire, and many others. Third was the evaluation of care for many different conditions – for example a series of presentations on the care of asthma, depression, dementia, and diabetes.

I was amazed at how much is going on. Every country in Europe is, in one way or another, confronting the question of quality assurance in general practice. Quite how information about all this activity can be exchanged efficiently is unclear, but it is likely that someone in a distant corner of Europe is already tackling problems we are only just becoming aware of. My impression was that the Netherlands and the United Kingdom are the two foremost countries in quality in general practice. That is not to say that they have the best methods or the most original approaches but, at least temporarily, British and Dutch colleagues are showing the way.

Although family practice in the different countries of Europe may have much in common, clearly there is also great diversity – for example, in the funding arrangements, the facilities, and whether doctors work in large groups or clinics with a range of nursing and other staff or whether they work alone. In some