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

countries most general practitioners use computers, in others this is unusual. I suspect there would be much less variation in the habits of clinical management in some specialist services, but general practice by its nature is influenced by the social and cultural setting and must respond to the perspectives of the patient population. In screening and health promotion this was most strongly apparent. Enthusiasm for screening various patient groups varied widely. In the presentations about cervical and breast screening programmes from France, Denmark, the Netherlands, and Belgium general practitioners featured in various roles from no direct role to performer of the test.

Ten years ago it would have been impossible to imagine that the volume of research presented at this congress could ever emerge from European general practice. Most of the countries represented are still at an early stage of development of the discipline of general practice; in another ten years it will be impossible to illustrate the work of general practice in a single congress.

RICHARD BAKER

Director, Eli Lilly National Clinical Audit Centre

Second national symposium on the future of medical audit in general practice, Chepstow, March 1993

The national symposium on medical audit in general practice, organised by the Eli Lilly National Clinical Audit Centre, provided a timely opportunity to reflect on progress and included reports of two studies of the work of MAAGs and progress from regional and Department of Health perspectives. Several MAAGs also presented projects as examples of what is being undertaken. The high turnout of FHSA managers; MAAG chairmen, members, and staff; and representatives from the Department of Health ensured full and lively participation. The main theme of the discussions centred on the relation between FHSAs and MAAGs. On the one hand MAAGs feel they must have the confidence of local practices, but on the other the FHSA must be convinced that the money and time devoted to audit can be justified. There was a feeling of advancement since the early debate about confidentiality, but there is still a long way to go before FHSAs and MAAGs are working together as effectively as possible. Happily, there was ample evidence from both speakers and audience that the need for dialogue is widely appreciated, and in some areas new approaches are being used to facilitate this development.

The involvement of staff members of the FHSA in the daily affairs of the MAAG varies considerably from one county to another. Often medical advisers, and occasionally general managers, are appointed MAAG members and are privy to all that goes on. In my own FHSA, Gloucestershire, the feeling from the

outset was that if medical audit was to be perceived as being led by the profession for the profession any involvement of FHSA management should be minimal. The medical director was thus appointed as administrative liaison member of the MAAG – a function that enabled a defined link with FHSA officers but allowed the monthly deliberations of the group to proceed unwatched by anyone from the FHSA management team.

The credibility of the MAAG teams visiting practices is vital. Their function has to be seen by general practice partners and their staff as constructive and educational, and the considerable achievement of reaching all practices would have been seriously hampered by perceptions of covert investigation by the FHSA.

Now is a crucial time from the FHSA viewpoint: the initial flurry of activity has reached a plateau, with practices operating the audit programmes they were encouraged to set up by MAAG members. Without further spurs to activity there is a danger that enthusiasm will wane and audit cycles will be uncompleted, and this would undoubtedly lead the NHS Management Executive to look at a more formal basis for medical audit in general practice.

Perhaps surprisingly, resources for audit did not feature much in the symposium discussions. Unlike others, Gloucestershire FHSA has not made available a predetermined amount of money at the outset; resources have been released according to estimates of need. Although both the FHSA and the MAAG have been aware of a need to limit funding, we have had no complaints about inadequate staffing, equipment, or activity resulting from underfunding.

The time required to do audit properly – the commonest problem voiced about medical audit – was acknowledged during the symposium. The offer locally of the services of an audit assistant was slow to be taken up by practices at first, but increased towards the latter part of the past year. FHSAs can help – especially the reluctant practices – by targeting resources at this particular area. In Gloucestershire we are careful to leave the management of these resources to the MAAG.

Looking ahead, the FHSA expects the activities of the MAAG to produce demonstrable benefits to patients. Audit exercises are of no value unless change is instigated where the need for it has been identified. It is a matter of some pride to a practice when it can show that it has looked at what it is doing, found a need for improvement and made the alterations necessary to show an improvement “next time around”.

There has been wide discussion about the possible exchange of information specific to practices between MAAGs and FHSAs, but any FHSA carrying out its role responsibly and effectively should be able to predict the likely levels of audit activity or response to MAAG members from all of its practices. Audit is not the tool which FHSAs should use to identify poor quality practices – or indeed top

quality practices – for that there are many better ways and means.

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COMMENT

The Interface between Clinical Audit and Management. Working Group of the Clinical Resource and Audit Group of the NHS in Scotland (pp 51, free to NHS staff). Edinburgh: HMSO, 1993.

This report explores the interface between clinical audit and management and proposes a set of principles for both health care professionals responsible for clinical care and the managers responsible for the effective use of expensive resources. Comprehensive and well structured, the report contains much common sense in its recognition of the different perspectives and views of the full range of stakeholders in clinical audit.

From the managerial viewpoint the report addresses the important issues in clinical audit – a definition of what clinical audit is *not*, that audit should be an integral part of daily practice, that evidence of audit activity is not evidence of effective audit, recognition of the distinction between quality of service issues for managers and the quality of clinical care for clinical health care professionals, and the need for consumer involvement in the process.

The report is particularly good on the subject of reporting the results of audit, an issue of crucial importance to managers in both provider and purchaser organisations. It recognises the need for differentials in the level of reporting detail and interpretation of audit results and proposes a five level organisation of audit information to interested teams and organisations. Also it suggests that ways are needed to allow data to be shared rather than requiring the same data to be inputted multiple times in different information systems.

The working group acknowledge the growing sense of frustration about the apparent failure of clinical audit to provide at least some definitive outcome measures for inclusion in service contracts. The report suggests that “clinical audit could fill this void in a short time” and takes sensible views on outcome measurement but, sadly, makes no definitive recommendations, referring to another Scottish working group considering the outcomes issue.

The report will be of value to any UK based clinician or manager interested in audit and outcomes. Its approach is structured and comprehensive and the analysis is well thought through and presented. “Calls to action” are few, even for the Scots audience. This is not a report which should be relegated to the shelf.

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