following criterion: 8% complete audit, 7% full audit, 31% partial audit, 13% potential audit, 15% planned audit, and 22% planning audit. At that time 4% were performing no audits, but this has subsequently been reduced to 0%.

Our two new categories are compatible with the system described by Derry et al and we hope they will prove useful to others. We agree that the usefulness of this systematic coding system will be to provide information on the progress of audit in the county and to identify those practices in need of help in pursuing their audits. We use the coding method to help us to focus our activities more effectively in facilitating the development of medical audit in Wiltshire and not in a point scoring or punitive fashion.

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BOOK REVIEWS


As the NHS takes its first filtering footsteps into the new era the need for contemporary, up-to-date measures has become clear. Nowhere is the need more acute than in rehabilitation and disability medicine. Evaluation is urgently needed, both to identify efficacious intervention and to convince potential purchasers of its cost effectiveness. Whether for clinical use, research, audit, marketing, or any other reason, measurement is mandatory.

Not that there has been any shortage of attempts at measurement. On the contrary. Nearly every self respecting rehabilitation department in the country has developed its own scale for this or that — Frenchy, Northwich Park, Nottingham, Oswestry, Rivermead, to name but a few (and only on this side of the Atlantic). There are scores of different types of impairment (motor, sensory, cognitive, and emotional); scales for the different levels in the World Health Organisation model of illness (impairment, disability, handicap); and scales which address the impact of disease on the patients and on those around them, scales which are disease-specific, and scales which are more general. To use a musical metaphor, some scales are almost chromatic in their compactness and attention to detail, while others give an anguilo-like span of the subject. Knowing which to use can be the biggest problem of all.

Derek Wade’s new book is an answer to our prayers. Not only does it act as a reference guide to the completed and used assessments but it also gives specific advice on the choice and use of different measures. Many will be familiar with the difficulties, having read a research article, of discovering which is the outcome measure used. The original scale turns out to have been published in a journal or book which is not readily available and proves, what does arrive, to be in Swedish. Validation, if undertaken at all, has usually been published in a subsequent issue, etc. The fourth section of this heavy sent book gives full details of over 100 measures accompanied by the author’s comment on the characteristics (reliability, validity, etc) of the scale.

In a book which attempts to outline the available choices in an unbiased fashion one might expect to be left with yet another wealth of information and little clear guidance. But not so. In chapter 12, the author lays out very clearly his own choice of measurements in the specific circumstances of his two units (one an acute rehabilitation centre, the other a young disabled unit), always with his eye on economy and relevance. The book will be invaluable for anyone involved in service provision, audit, evaluation, research, or planning future services for patients with neurological disability.

LYNNE TURNER-STOKES
Consultant in Rehabilitation


In the 1970s audit was a term that was used rarely in medical parlance in the United Kingdom. In 1980, however, the BMJ brought audit to the attention of many in the medical profession by publishing a series of five introductory articles by Charles Shaw. Drawing mainly on his own experience and knowledge of quality assurance in the United States, Shaw summarised the key principles of audit and, incredibly, in two short papers was able to document the audit activity in hospitals and general practice in Britain. His paper on the acceptability of audit was written against a general background of decided lack of enthusiasm and suspicion of audit among doctors.

When writing “Looking forward to audit”, Shaw probably did not realise that he would have to wait almost 10 years before it became a reality in the NHS. In the mid 1980s there were isolated pockets of activity among several groups — for example, the Royal College of Radiologists’ multi-centre audit of the use of routine and diagnostic procedures, the Lothian surgical audit of mortality and complications after surgery, the Royal College of General Practitioners’ practice activity analysis, and the Confidential Enquiry into Maternal Deaths. Much good work was carried out, methods were explored, and a small cadre of individuals became adept at the dos and don’ts of audit, while publishing sporadically in the general and specialist medical journals.

After publication of the government’s white paper Working for Patients in 1989 (ref. 1) and an editorial in BMJ responding to the fervour by including a special section on medical audit, we provide information on the progress of audit in the country and to identify those practices in need of help in pursuing their audits. We use the coding method to help us to focus our activities more effectively in facilitating the development of medical audit in Wiltshire and not in a point scoring or punitive fashion.


Hugh Koch’s excellent book goes much further than the usual basic text on quality, which is often “soft” in its approach and leaves people wondering: “That’s all very well, but . . . .” It comes much more from his consultancy work and is grounded in practice and refreshingly aware of all the connections between total quality management.