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 Berry 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 faltering footsteps into the new era the need for controlled outcomes 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, Northwick Park, Nottingham, Oswestry, Rivermead, to name but a few (and only on this side of the the Atlantic). There are scales which measure 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 anguilliform like span of the subject. Knowing which use to 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 commonly 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, in discovering exactly what 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 heaven sent book gives full details of over 100 measures accompanied by the author's comment on the characteristics (validity, reliability, 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 an 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 the BMJ published any follow up articles. In the until audits of the 1980s there were isolated pockets of activity among several groups - for example, the Royal College of Radiologists' multimethod audits of the use of routine 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 experts at doing and doing 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 came the National Audit Act, 1991, which BMJ responded to the fervour by including a special section on medical audit. In this section were articles published dealing with many aspects of the audit process, not least those of Charles Shaw's early papers, are now brought together in Audit in Action. In 30 chapters surgeons, physicians, specialists in public health medicine, audit officers, sociologists, and others, mainly from the United Kingdom, provide a rich insight into audit.

An appropriate organisational framework is often the key to success in audit, and this is addressed in an early section of the book. What is the role of regional specialty subcommittees? How should an individual clinician get started? What should audit officers do? In the following chapter on "Making a credit handout" the methodological issues are addressed - for example, techniques of reviewing medical records and surveying patient satisfaction. Here the book emphasises two important points: first, do not expect board in the United Kingdom - namely, setting audit objectives and the use of explicit criteria of good practice. This latter approach is one way of orienting the emphasis of audit from simply collecting data to making improvements in the quality of care. Clinicians wishing to do this would be advised to concentrate on a chapter on criterion based audit and use Bhopal and Thomson's form, described in a later chapter, as a means of educating themselves about audit when reading papers.

The final two chapters on total quality management, by Berwick, Enthoven, and Bunker from the United States, take us forward from the narrow confines of medical audit to the broader view of the audit industry that striving for improved quality, not just maintaining the status quo, should pervade every aspect of the organisation and be an ideal that is incorporated into every everyday task. If a philosophy is not quite with us in the NHS but Audit in Action, as well as providing some useful insights into audit, may help to move us in that direction.


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 so is grounded in practice and refreshingly aware of all the connections between total quality management...