

## LETTERS

### Role of the Clinical Standards Advisory Group

Sir Gordon Higginson sets out very clearly the membership of the Clinical Standards Advisory Group, the operation of the group, and its current remit.<sup>1</sup> The section with which I take issue, however, is that entitled "Emphasising the multidisciplinary approach." Anybody with any knowledge of the clinical manpower of the health service will see immediately that although the medical and nursing professions are well represented, a substantial group – namely the professions allied to medicine – are not represented. With due respect, the group cannot therefore reflect true multidisciplinary clinical standards, and if the remit areas are inspected closely, concern must be expressed that standards in cystic fibrosis and diabetes are being discussed without the input of the dietetic and physiotherapy professions.

The argument that having representatives of all the professions allied to medicine makes any group too big is undermined by the numbers and range of the medical and nursing representatives as set out in the second paragraph of the article.

So yet again, the myth that the NHS is clinically staffed only by doctors and nurses is perpetuated; this causes anger, frustration, isolation, and lowering of morale, which could so easily be avoided.

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1 Higginson G. Role of the Clinical Standards Advisory Group. *Quality in Health Care* 1992;1(suppl):S34-5.

### Factors influencing default at a hospital colposcopy clinic

I read with interest the report by Gillian Sanders and colleagues.<sup>1</sup> I report a pilot study carried out to examine the high rate of altered appointments at the main hospital colposcopy clinic for Lothian Health Board (population 750 000). Monthly figures suggested that 26% – 38% of all appointments at the clinic were either cancelled or not attended. The pilot study was carried out to discover if this meant that the same percentage of women failed to receive adequate treatment.

One hundred consecutive general practitioner referrals of women to the clinic were examined and the progress of these women was followed throughout their attendances at the hospital. Whether they kept the first appointment sent to them, cancelled it by telephone, or did not attend for consultation was noted. Records for the clinic were not kept far

enough back to allow complete analysis of the cohort, despite studying a four year period, but some facts emerged.

In total, 590 appointments were arranged for these women over this period, of which 157(27%) were altered (percentage altered appointments for individual clinics ranged from 6% to 38%). All 100 women eventually attended the first two clinic sessions (for diagnostic colposcopy and for treatment), 98 women attended the third session (for check cervical smear) and 90 attended for colposcopic re-examination. Eighty two women had completed the course with the last appointment (cervical screening) pending, and 13 women were still due to attend for second treatments. Only five women had been lost to the system at the time of the study.

Although it was not possible to complete the attendance histories of all 100 women, the results strongly suggested that most women attended all sessions but frequently altered appointments along the way. Why this should happen was not investigated at the time. It is possible that attendance at hospital for treatment as a result of abnormal findings from a screening procedure may be viewed differently from attendance for treatment when problems have been identified by the patients themselves.

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1 Sanders G, Craddock C, Wagstaff I. Factors influencing default at a hospital colposcopy clinic. *Quality in Health Care* 1992;1: 236-40.

### Prospective audit comparing ambulatory day surgery with inpatient surgery for treating cataracts

Effectiveness and efficiency are two important dimensions of quality, and randomised controlled trials are in many situations the most reliable way of assessing these dimensions<sup>1</sup> so the trial of two ways of providing cataract surgery described by Percival and Setty<sup>2</sup> was especially useful, and we applaud your publishing it.

But how was the hurried reader to know that this was a trial? There was no hint that patients had been randomised to the two treatment options (so greatly increasing the chances that like was being compared with like) in either the title or the structured abstract. Only the methods section made this crucial point clear. This oversight meant that an important paper might easily have been missed by a reader looking for studies free from the selection bias inherent in non-randomised studies.

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1 Department of Health. *Assessing the effects of health technologies*. London: DoH, 1992.

2 Percival SPB, Setty SS. Prospective audit comparing ambulatory day surgery with inpatient surgery for treating cataracts. *Quality in Health Care* 1992;1:38-42.

### Perceptions of audit activity

Firth-Cozens and Storer have drawn attention to the difficulties of involving and engaging doctors in the audit process.<sup>1</sup> In the summer of 1992 the medical unit's junior doctors at St Albans City Hospital were each asked to undertake an audit project of their choice and to complete it for presentation at the end of six months.

Monthly meetings, supervised mainly by two consultants and the audit project officer, were held to guide each project design. With one exception, all the juniors (including house officers) participated. The projects which were presented at the end of January, were briefly as follows. (1) Patients' understanding of and compliance with domiciliary oxygen treatment were assessed by postal questionnaire. Results showed that the level of comprehension, and therefore compliance, was poor; consequently the patient information leaflets are being revised. (2) Case notes were audited retrospectively to determine documentation and management of hyponatraemia. Poor performance was suggested to be due to lack of knowledge among juniors. Thus the biochemistry department are reassessing the optimal method of alerting clinicians, and further teaching was suggested. (3) Reassurance among patients with normal gastroscopies was evaluated with questionnaires. A significant proportion were not reassured at two weeks; this topic is being used as a pilot project to design a study aimed at identifying such patients. (4) An audit about the satisfaction of medical patients attending the accident and emergency department showed that most were pleased with their care. Dissatisfaction seemed to be mainly related to long waiting times for ward beds. Inappropriate use of juniors in finding beds and non-adherence to the admissions policy were highlighted. (5) Patients with chronic airflow limitation and ischaemic heart disease who had a history of smoking were asked about the adequacy of information and support given by hospital doctors and other services to help stop smoking. This led to the suggestion that easily accessible information materials and regular medical advice could improve this area further.

The restriction imposed by "one in three" rotas and a six month deadline added an element of chore to the projects and also limited the ability to close the audit loop. Regular guidance on an individual basis would have been less intimidating and more helpful, as highlighted recently.<sup>1</sup> However, there was interest and support from most consultants and ample practical help from the audit office. The adequate financial incentive was not felt to have generated greater enthusiasm.