referral guideline had actually been measured.

A key theme of the book is how little wisdom has so far been yielded by our knowledge. Problems of allowing for differences in age structure and case mix and for the effects of random variation make referral rates difficult to interpret. Existing systems for collecting the data are often unreliable. But having obtained reliable data, we move on to a greater problem; to quote David Wilkin, "Because we know nothing about the appropriateness of referrals or their outcomes for patients, we do not know whether wide variations in patterns of referral are a sign of inefficiency, or whether reducing variation will increase efficiency."

There is a paradox here, in that almost any district general hospital consultant knows, for his or her specialty and his or her own patch, the answer that is eluding the collective efforts of the data collectors – namely, which general practitioners tend to refer too soon and which tend to refer too late. Conversely, general practitioners, particularly if they organise the sharing of information on referral outcome, know more about the quality of hospital services than is likely to emerge from any provider's prospectus. Improving the functioning of the referral system is much more likely to be achieved by constructive and sensitive use of this sort of local knowledge than by the collection and publication of uninterpretable statistics by family health services authorities. It remains to be seen whether the adversarial environment engendered by the reforms will prove conducive to initiatives of this kind, but anyone seeking to make the referral system work better should read this book first.

DUNCAN KEELEY
General Practitioner

Clinical guidelines. Report of a local initiative. Haines A, Hurwitz B, eds (pp 91; £11.50). London: Royal College of General Practitioners, 1992. (Occasional paper 58.) ISBN 0-85084-179-8.

Protocols are a growth industry. In the United Kingdom they have been produced by general practitioners for contractual reasons, particularly in order to obtain approval and thereby payment for health promotion activities and surveillance of chronic disease. Clear statements of performance are also seen as an essential part of the audit process, encouraged by medical audit advisory groups. This emphasis on each practice producing its own protocols and guidelines is in contrast to the approach of other countries, notably the Netherlands, where national guidelines have been published for a wide range of conditions.

This occasional paper presents an alternative approach: the development of guidelines in one locality, initiated by an academic department and resourced by local hospital specialists and general practitioners. The family health services authority supported the initiative by

printing and distributing the guidelines locally. The fact that these local guidelines have been published as an occasional paper for a national and international readership suggests that the Royal College of General Practitioners wants to stimulate a debate about the use of protocols. In his preface Professor Pereira Gray suggests that it may soon be necessary (sic) for the college council to endorse protocols formally.

The occasional paper starts with a review of the principles underpinning guidelines, the evidence of guidelines' effectiveness, and the methods used in Islington. The bulk of the paper is the guidelines themselves, of which there are fifteen, ranging from chronic diseases such as diabetes and asthma and health promotion topics such as cardiovascular disease, child health surveillance, and management of chronic drinkers to clinical areas of general practice such as ophthalmology and skin diseases. The authors state that conditions were selected on the basis of accounting for 10 or more consultations per 1000 in general practice.

In their introduction the authors describe how guidelines can be designed by four methods: subjective judgment, evidence based, outcomes based and preference based (that is, including the public's opinions). All the chapters, most of which are co-authored by a general practitioner and hospital specialist, are in the first two categories. The extent to which research evidence is cited varies, with over twenty references at the end of the chapter on cardiovascular disease, and none for the chapter on skin diseases and ophthalmology. This diversity reflects the different approaches used; for some conditions, such as asthma, simple algorithms are used whereas other chapters are descriptive in the undergraduate textbook mode, sometimes with unnecessarily detailed appendices on such issues as specific screening procedures in children. All chapters end with suggestions for audit, which, not surprisingly, are most useful in those chapters which contain explicit standards of care.

Practitioners differ in the amount they read, the type of material they read, and when they read it and particularly in their use of reference materials during consultations. The guidelines in this publication could be used in three ways: during consultations, in formulating a practice policy, and in developing similar initiatives in other health districts. There is a paradox at the heart of the trend towards guidelines; the evidence suggests that they influence only those actively engaged in their formulation whereas it is obvious that one person has not the time nor energy to address more than a small area of practice. By providing a template on which practices or districts can build this publication fulfils an important function. It is also a refreshingly concise account of current approaches to important aspects of primary care.

ANDREW WILSON
Senior Lecturer in General Practice

Audit and Development in Primary Care. Humphrey C, Hughes J (pp 82; £9.50). London: King's Fund, 1992 (Medical Audit Series 5.) ISBN 1-85717-030-X.

When audit in primary care became a government objective the strategy was to encourage and facilitate it in whatever way seemed appropriate for the setting. The result has been, as described in *Audit and Development in Primary Care*, confetti audit.

One of the problems of this model is the difficulty in getting a feel of what is really happening and of seeing the whole picture. The major achievement of this book is that it is an anthology with comment of primary care audit as it is now. There is a lot of good reading for all facilitators and advisors in audit. There seems to be no unnecessary repetition of examples, and from my personal experience of the examples quoted, the reporting is accurate.

However, this book is more than an anthology. It is a reasoned argument for the development of audit along particular lines – the lines of a managed service. There is no exploration of the debate that this method has been so successful because it corresponds so well with general practice as it is, and that this should be the underlying philosophy to be developed. This would not in itself be a problem except that the first major part of the book is the executive summary, and that is where health care planners and strategists often begin and end their reading. If we, the profession, wish to see audit develop along different lines we have to start saying so now.

I would have liked to see a glossary of the terms, such as broker and stakeholder. They are explained but not defined in the text, and there is scope for the reader to take them beyond their original meaning. The idea of an audit broker is new and could have been developed to help those unfamiliar with these management terms to grasp the concept. For instance, broker is listed with facilitator and champions of change, but the role as described in the text is as one who promotes collaboration between local practitioners and establishes vertical links between primary care and the interested service agencies. Many facilitators who have fostered their practices with assurances of confidentiality and separation from the family health services authorities will be anxious to see their job develop in this way. Much time and effort have been invested in neutralising the paranoia in the grass roots. The investment should be seen as planting trees not as a cash crop. Patient development based on an educational foundation is likely to lead to fruitful outcome. The policy makers and planners would do well to listen to the enthusiasts in primary care who have championed the changes and causes, before making hasty moves towards synthesising the educational with what might be construed as regulatory audit.

However, the profession does have a wider responsibility to the public and,

with the service agencies, has a common aim of improving the quality of patient care. Audit methodology is ideal for promoting shared objectives. The decision is when and how; there is enough material within the 84 pages of this book to open the debate.

This is much needed, well presented book which will help all of those involved to see the depth and breadth of the audit experiment. For this reason alone it is valuable. It should be digested by all who have views on the future of audit because its arguments are forceful and seductive. If you agree, fine; if not, start mustering the evidence; the potential agenda for the next stage has been written, and you can read it here.

ARTHUR HIBBLE
General Practitioner

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.)

LEARNING TOOLS

Clinical Audit Training Package. Association of Management Education of Clinicians, West Midlands Regional Health Authority (CD, workbook (67 pp), disk; £126.50 plus VAT), 1992.

The *Clinical Audit Training Package* consists of three items: an audio compact disk (CD), a workbook, and a 3.5" diskette for an IBM compatible personal computer. The first part of the package, the CD, contains a comprehensive commentary on all the current aspects of clinical and medical audit, subdivided into chapters: starting with the historical and chronological background of audit, it continues through the basic concepts and definitions of audit and finishes with a framework and action plan for actual audit projects. The second part of the package is a workbook containing more detail than can be provided on the CD – namely, further chronological particulars, a glossary of terms, approaches to audit, and many of the original (and important) Department of Health (DOH) and royal college reports and documents pertaining to the development of audit. Two detailed examples of actual audits are also given, using the framework outlined in the CD. The third part of the package is an interactive tutorial on diskette for developing a framework for audit, which contains a facility for programming

specific audits. By using the "print screen" function hard print copies of the tutorial can be obtained.

To be honest, initially I viewed this tripartite package with some scepticism, feeling that it was a bit "gimmicky." However my initial cynicism was quickly dispelled as I progressed through the CD and workbook. The CD narrative is clear, interesting (it is read by a Joss Ackland "sound alike"), and concise. The workbook starts out in standard "book about audit" fashion but quickly becomes relevant to the needs of practising clinicians, with examples of what can (or should) be done. I particularly liked the compilation of relevant Department of Health documents – some are apt to forget the importance with which the department and the royal colleges see the development of medical audit. The computer tutorial is fun and easy to use and gave me some good ideas.

This is an excellent training package for educating all health care workers (including clinicians, managers, and audit coordinators) about clinical audit. Instead of simply reading about how to do an audit, you are also listening and interacting with a computer; this undoubtedly makes for more interesting and entertaining learning. The boredom threshold is raised, and I found myself happily entertained with the package for quite some time, having intended to give it only my "standard" review time.

This package should be available in every audit office. For audit assistants and audit coordinators it is a simple way to quickly assimilate the background on audit and impart ideas of how to establish an audit. For clinicians who are already familiar with the concepts of audit it is an excellent reference source and stimulator of fresh ideas.

MERON JACYNA
Consultant Physician

The package is available from Nathan Laxton, Project Administrator TEACH Project Office, Regional Training Department, Edgbaston Road, Edgbaston, Birmingham B16 9SA (tel 021 456 5566 ext 2096; fax 021 454 7483). The CD is available alternatively as an audiocassette tape or interactive disk.

MEETINGS REPORTS

Audit and development in primary care, London, February 1993.

A statutory structure to promote medical audit for general practice was set up from April 1990, and by April 1991 all general practitioners were meant to be taking part. There has been a sudden burst of activity with audit support staff being employed; strategies to promote audit, such as practice visiting and multipractice audits being implemented; together with the publication of newsletters and provision of

education for practice teams. It is now appropriate to take stock of these early developments. Several themes are beginning to emerge, including questions about value for money, the role of patients, and the need to overcome the isolation of medical audit from all the other arrangements in the health service for managing quality. This meeting provided an opportunity to consider these issues.

In 1990 the King's Fund Centre published a book *Medical Audit in General Practice: a Practical Guide to the Literature*. The authors, Charlotte Humphrey and Jane Hughes, have now published a second volume – *Audit and Development in Primary Care*, which contains a report from a series of interviews and visits they undertook to review the recent progress of audit in general practice. They did not confine themselves to audit promoted by medical audit advisory groups (MAAGs) but also examined initiatives undertaken by academic departments of general practice and other projects not related to MAAGs. Several presentations during this meeting to launch their report were of projects described in their new book.

The issues confronting MAAGs that were identified included the need to provide evidence that money spent on medical audit does lead to worthwhile improvements in care for patients. The place of audit in relation to all the other approaches used to maintain quality was raised, such as accreditation, continuous improvement, or risk management, and the future of MAAGs themselves was debated. MAAGs are dominated by the medical profession, whereas primary care is provided by a diverse range of professionals. Nurses, pharmacists, and almost every other group are becoming interested in audit – should MAAGs enlarge to include the other members of primary care (clinical audit advisory groups) or should each professional group have its own committee?

The presentations on different approaches to audit provided a helpful background to the debate about the direction in which MAAGs should develop. There was a report of an audit conducted between general practice and a hospital on communication, a report from a long running audit group for general practitioners in Newcastle, and a significant event audit of a postnatal death.

The themes were brought together in the final presentation by Christine Wall, general manager of Liverpool Family Health Services Authority (FHSA). She declared that much money had been spent on audit and provided alternative examples of how this could have been used to provide patient care. There are the opportunity costs of audit, and they served to emphasise the need to demonstrate the value of audit in terms of improvements in care. The activities of Liverpool MAAG were then described; the audience was relieved to hear that the manager was satisfied and continued to support the development of audit. However, this threw down the gauntlet to