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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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 referred to by 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 outcomes are not mentioned about all using the same work 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 in relation to audit sessions. 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 other texts.

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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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 General Practitioners and Family Physicians) (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 topics 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 with those in the other, it is the 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