countries most general practitioners use computers, in others this is unusual. I suspect there would be much less variation in the habits of clinical management in some specialist services, but general practice by its nature is influenced by the social and cultural setting and must respond to the perspectives of the patient population. In screening and health promotion this was most strongly apparent. Enthusiasm for screening various patient groups varied widely. In the presentations about cervical and breast screening programmes from France, Denmark, the Netherlands, and Belgium general practitioners featured in various roles from no direct role to performer of the test.

Ten years ago it would have been impossible to imagine that the volume of research presented at this congress could ever emerge from European general practice. Most of the countries represented are still at an early stage of development of the discipline of general practice; in another ten years it will be impossible to illustrate the work of general practice in a single congress.

Second national symposium on the future of medical audit in general practice, Chepstow, March 1993

The national symposium on medical audit in general practice, organised by the Eli Lilly National Clinical Audit Centre, provided a timely opportunity to reflect on progress and included reports of two studies of the work of MAAGs and progress from regional and Department of Health perspective. National MAAGs also presented projects as examples of what is being undertaken. The high turnout of FHSA managers; MAAG chairmen, members, and staff; and representatives from the Department of Health ensured full interest and participation. The main theme of the discussions centred on the relation between FHSA and MAAGs. On the one hand MAAGs feel they must have the confidence of local practices, but on the other the FHSA must be convinced that the money and time devoted to audit can be justified. There was a feeling of advancement since the early debate about confidentiality, but there is still a long way to go before FHSA and MAAGs are working together as effectively as possible. Happily, there was ample evidence from both speakers and audience that the need for dialogue is widely appreciated, and in some areas new approaches are being used to facilitate this development.

The involvement of staff members of the FHSA in the daily affairs of the MAAG varies considerably from one county to another. Often medical advisers, and occasionally general managers, are appointed MAAG members and are privy to all that goes on. In my own FHSA, Gloucestershire, the feeling from the outset was that if medical audit was to be perceived as being led by the profession for the profession any involvement of FHSA management should be minimal. The medical director was thus appointed as administrative liaison member of the MAAG – a function that enabled a defined link with FHSA officers but allowed the monthly deliberations of the group to proceed unwatched by anyone from the FHSA management team.

The credibility of the MAAG teams visiting practices is vital. Their function has to be seen by general practice partners and their staff as constructive and educational, and the considerable achievement of reaching all practices would have been seriously hampered by perceptions of covert investigation by the FHSA.

Now is a crucial time from the FHSA viewpoint: the initial flurry of activity has reached a plateau, with practices operating the audit programmes they were encouraged to set up by MAAG members. Without further spurts to activity there is a danger that enthusiasm will wane and audit cycles will be uncompleted, and this would undeniably lead the NHS Management Executive to look at a more formal basis for medical audit in general practice.

Perhaps surprisingly, resources for audit did not feature much in the symposium discussions. Unlike others, Gloucestershire FHSA has not made available a predetermined amount of money at the outset; resources have been released according to estimates of need. Although both the FHSA and the MAAG have been aware of a need to limit funding, we have had no complaints about inadequate staffing, equipment, or activity resulting from underfunding.

The time required to do audit properly – the commonest problem voiced about medical audit – was acknowledged during the symposium. Locally the time of the services of an audit assistant was slow to be taken up by practices at first, but increased towards the latter part of the past year. FHSA can help – especially the MAAG – to find resources and the likely level of audit is being scrutinised.

There have been widespread discussion about the possible exchange of information specific to practices between MAAGs and FHSA, but FHSA carrying out its role responibly and effectively should be able to predict the likely levels of audit activity or response to MAAG members from all of its practices. Audit is not the tool which FHSA should use to identify poor quality practices – or indeed top quality practices – for that there are many better ways and means.

STEPHEN GOLLEDGE
Chief Executive, Gloucestershire Health


This report explores the interface between clinical audit and management and proposes a set of principles for both health care professionals responsible for clinical care and the managers responsible for the effective use of expensive resources. Comprehensive and well structured, the report contains much common sense, its recognition of the different perspectives and views of the full range of stakeholders in clinical audit.

From the managerial viewpoint the report addresses the important issues in clinical audit – a definition of what clinical audit is not, that audit should be an integral part of daily practice, that evidence of audit activity is not evidence of effective audit, recognition of the distinction between quality of service issues for managers and the quality of clinical care for clinical care professionals, and the need for consumer involvement in the process.

The report is particularly good on the subject of reporting the results of audit, an issue of crucial importance to managers in both provider and purchaser organisations. It recognises the need for differentials in the level of reporting detail and interpretation of audit results and proposes a five level organisation of audit information to interested teams and organisations. Also it suggests that ways are needed to allow data to be shared rather than requiring the same data to be inputted multiple times in different information systems.

The working group acknowledge the growing sense of frustration about the apparent failure of clinical audit to provide at least some definitive outcome measures for inclusion in service contracts. The report suggests that "clinical audit could fill this void in a short time" and takes sensible views on outcome measurement but, sadly, makes no definitive recommendations, referring to another Scottish working group considering the outcomes issue.

The report will be of value to any UK based clinician or manager interested in audit and outcomes. Its approach is structured and comprehensive and the analysis is well thought through and presented. "Calls to action" are few, even for the Scots audience. This is not a report which should be relegated to the shelf.

PAM GARSIDE
Head of Organisational Development, North West Thames Regional Health Authority