LETTERS

Problems with implementing guidelines: a randomised controlled trial of consensus management of dyspepsia

The study by Roger Jones *et al*¹ attempts to use quarterly prescribing analysis and cost (PACT) data as a measure of evaluating the introduction of guidelines for the management of dyspepsia. The authors draw attention to the appreciable individual variation in baseline prescribing costs among the general practitioners (GPs) in both the study and control groups. Though the mean cost per GP for upper gastrointestinal drugs does indeed vary by a factor of between 40-55 we are not told to what extent any variation in the individual list size or the number of prescribing units for each GP may account for this feature. Inconsistencies of this nature at the level of individual GPs may not of course appear when examining groups of GPs, as illustrated by the lack of significant difference in the number of items prescribed by group.

Unfortunately, we are not told when the study took place, other than it was before the date of publication of reference fourteen (1991), and we cannot therefore judge as to the influence on the study of any prescriptions for omeprazole. Table 4 and the results section refer to prescribing costs per GP for ulcer healing agents before and after the introduction of the guidelines (this *British National Formulary* category would have included omeprazole if it had been available) whereas the discussion section mentions only the use of H₂-antagonists. As an example of the uptake of this drug, within this family health service authority for the past two quarters in 1990 the cost of prescriptions for omeprazole grew 35%. Rather than assuming that the guidelines brought about a change in behaviour, could those "innovative" GPs within the study group simply have switched from traditional treatments to what may have been then the new "wonder drug" omeprazole, thereby subsequently raising their prescribing costs?

MICHAEL WILCOCK
Cornwall and Isles of Scilly District and Family Health
Services Authorities,
St Austell,
Cornwall PL25 4DJ

1 Jones RH, Lydeard S, Dunleavy J. Problems with implementing guidelines: a randomised controlled trial of consensus management of dyspepsia. *Quality in Health Care* 1993;2: 217-21.

AUTHORS' REPLY

Michael Wilcock is correct. We did not set out to explain the variation in prescribing rates and costs among general practitioners, which is well documented elsewhere. Our data were corrected for

workload but not for prescribing units, and we did not think that before and after comparisons of the prescribing costs of individual general practitioners would yield meaningful information because of the influence of other variables. The only concern that we might have about the security of these data relates to the period of observation; the referral literature suggests that referral rates should be measured over periods of at least six months to avoid natural variation, and it might be that prescribing costs vary in response to factors such as case mix, seasonality, and changes in workload in a similar way.

The study guidelines were circulated in March 1990; although omeprazole was then available (having been released for prescribing by general practitioners in September 1989), the timescale was such that an effect on prescribing costs was unlikely. The steep rise in prescribing costs in the study group was, we believe, unrelated to the introduction of a "wonder drug." We would reiterate our contention that a "brakes off" recommendation in the guidelines is more likely to be followed than a constraining one, irrespective of the involvement of the target clinicians in the preparation of the guideline.

ROGER JONES
Department of General Practice,
United Medical and Dental Schools of Guy's and St
Thomas's Hospitals,
London SE11 6SP

SUSAN LYDEARD
Southampton University Hospital Trust,
Southampton

JOAN DUNLEAVEY
Department of Primary Medical Care,
University of Southampton,
Southampton SO1 6ST

Reducing unnecessary investigation of anterior uveitis

Anterior uveitis, or iritis, is a common cause of painful red eye presenting to casualty departments. It is characterised by ciliary injection, cells and flare in the anterior chamber, and synechiae formation between the iris and the lens. Unlike posterior uveitis or pan-uveitis, disease confined to only the anterior segment, or pure anterior uveitis, is rarely associated with systemic disorders such as sero-negative arthritis, secondary syphilis, and granulomatous conditions such as sarcoidosis and tuberculosis.^{1,2} Despite this, and in the absence of any supporting evidence, a bank of screening investigations is often ordered.

To document the extent of unnecessary investigations ordered for patients with anterior uveitis in our department in Newcastle General Hospital we audited the investigation of 93 cases of pure anterior uveitis in patients presenting to eye casualty for the first time in 1990. The most commonly ordered investigations were full blood count, urea and electrolytes, erythrocyte sedimentation rate, toxoplasma titre, autoantibodies, syphilis serology, and chest and sacroiliac joint x ray examinations (table 1). We were surprised at the number of investigations being ordered and the lack of useful information obtained; many of these tests we considered inappropriate. Most disturbing in view of exposure to ionising radiation was the number of x ray examinations being ordered; such examinations are rarely helpful in managing anterior uveitis.³ In those cases in which there was an underlying systemic disorder, for example, ankylosing spondylitis, the diagnosis was already apparent before the onset of anterior uveitis.

We had shown a problem of significant overinvestigation of patients with pure anterior uveitis. Instead of issuing prescriptive guidelines, we taught our junior staff about the importance of relevant aspects of history taking and encouraged them to select appropriate investigations on the basis of important features of the history, such as early morning stiffness and back pain, recent urinary tract infection, skin rashes, mouth or genital ulcers, and a history of inflammatory bowel disease, etc. Specific points on ophthalmic examination were highlighted as indicating a need for further examination, including iris granulomas, conjunctival follicles, and lacrimal gland infiltration. Through this positive approach to choosing appropriate investigations the departmental "folklore" of a panel of tests for all new cases of pure anterior uveitis was rejected.

To assess the effect of these changes in practice the study was repeated by auditing the investigations ordered for 94 new cases of pure anterior uveitis in 1992, when the number of inappropriate investigations was found to be significantly reduced (table 2). Serum calcium and angiotensin converting enzyme testing were ordered on more occasions suggesting that investigations were being tailored to identify sarcoidosis when appropriate. As in 1990, no new condition was disclosed.

Our primary aim was to ensure that cases of anterior uveitis were investigated more appropriately. The reason why a panel of investigations was being ordered

Table 1 Most commonly performed investigations in 93 patients with pure anterior uveitis, 1990

Investigation	No (%) of patients	No of positive results	Results acted on
Full blood count	59(63)	1 (neutrophilia)	no
Erythrocyte sedimentation rate	54(58)	3(>40)	no
Urea and electrolytes	51(55)	0	no
Toxoplasma titre	45(48)	7	no
Autoantibodies	40(43)	3	no
Syphilis serology	22(24)	0	no
Chest x ray examination	48(52)	0	no
Sacroiliac joint x ray examination	30(32)	1	no

Table 2 Investigations most commonly performed in 94 patients with pure anterior uveitis, 1992

Investigation	No (%) of patients (1992)
Full blood count	18(19)
Erythrocyte sedimentation rate	16(17)
Urea and electrolytes	2(2)
Toxoplasma titre	1(1)
Autoantibodies	3(3)
Syphilis serology	13(14)
Chest x ray examination	9(10)
Sacroiliac joint x ray examination	3(3)
Serum calcium	2(2)
Angiotensin converting enzyme*	3(3)

*Not included in 1990.

was not clear, but anterior uveitis is often diagnosed by relatively junior doctors in casualty departments and patients are then followed up in eye clinics led by a consultant. The panel of tests may have been ordered either "just to be safe," or because it was thought to be expected by the supervising consultant. Through focused teaching on the work of the junior staff a rational approach to investigation was encouraged whereby they stopped responding in a reflex fashion by ordering a panel of tests. In this instance encouraging clinical freedom was a successful approach and may have been more effective than clinical guidelines, which are often perceived as being prescriptive and are thought to remove clinical freedom.

R W D BELL
Princess Alexandra Eye Pavilion,
Royal Infirmary of Edinburgh,
Edinburgh EH3 9YW

P G GRIFFITHS
D GOODWIN
Newcastle General Hospital,
Newcastle upon Tyne

- 1 Forrester JV. Endogenous posterior uveitis: a brief review. *Br J Ophthalmol* 1990;74: 620-33.
- 2 Dinning WJ. *Systemic inflammatory disease and the eye*. Wright, 1987.
- 3 Austin MW, Clearkin LG. Radiological investigation in the management of uveitis. *Eye* 1988;2:578-9.

BOOK REVIEWS

Rationing in Action. (207 pp; £10.95). London: BMJ Publishing Group, 1993. ISBN 0-7279-0813-8.

Rationing, hitherto a relatively unseen pastime of clinicians, has been thrust into the spotlight as a by product of the 1991 NHS reforms now that health authorities are forced to be explicit how much health care they can buy, and it (or its less upbeat definition "allocating resources") has been hotly debated, defined, dismissed, and accepted over the past three years.

Although everyone wants a say, no one can agree how best to ration. Economists, of course, argue that rationers should spend money to maximise benefits in relation to costs. Doctors want to treat patients without interference but seem to want someone else to tell patients if a treatment cannot be afforded. Patients do not warm to the idea of care being rationed and politicians prefer a system where the blame stays local if care is denied, which is where NHS managers come in – they are caught in the middle and have to fend off the media.

It was this tangled mixture that the BMA, BMJ, King's Fund, and the Patients Association sought to unravel at a joint conference in March 1993 on setting priorities. *Rationing in Action* grew out of that conference, and it contains expanded conference contributions and key articles and letters on rationing which have appeared in the *BMJ* in the past three years. The contributors, who range from ethicists to journalists, politicians to policy analysts, and doctors to economists, provide the most comprehensive coverage of the debate yet published in the United Kingdom. Both the theory and practice of rationing are discussed in short and lively chapters which make for reading which is accessible for anyone interested in the subject and is essential for rationing gurus.

Perhaps the most reassuring aspect of *Rationing in Action* is that, despite the different perspectives reflected, there is surprising degree of consensus on such a difficult topic – namely, that there is no instant solution and that decision making will continue to be messy, emotive, challenging, and distinctly painful. This debate will run and run, and we should expect to see the key interest groups rehearsing similar arguments in public in future. Whether (or, more likely, when) a national core service for the NHS will be defined is not covered, but *Rationing in Action* is otherwise a welcome and timely reflection of current thinking.

JENNIFER DIXON
Senior Registrar in Public Health

Making Audit Work. Guidelines on selecting, planning, implementing and evaluating audit projects. Walshe K (pp 64; £7.00). London: CASPE Research, 1993.

Making Audit Work is a versatile tool for everyone involved in professional audit. An aide memoire for those experienced in audit, it also illustrates the philosophy and purpose of audit project management to newcomers to the scene; having read this booklet, most staff could manage any project more effectively.

The principles of audit management are clearly defined and the system of project management is logical, simple, and systematic, enabling the booklet to be used as a reference at any stage in the audit cycle. Both audit support staff and

other professional groups will benefit from this section. The methodologies presented should facilitate greater understanding between staff groups involved in the audit process and the possibility of increased discussion among audit support staff and staff undertaking specific audit projects.

Making Audit Work emphasises the importance of selecting projects that will lead to lasting improvements in quality, of ensuring that all staff (and clients?) who will be involved in a project are included early in the planning stage, and of project evaluation. Lessons may be learnt from both successful and failed projects, and evaluating what has happened within a project can provide opportunities to determine the effectiveness of audit, thereby contributing in the further development of the audit culture.

If any criticisms are to be made, they are that the criterion for selecting audit projects does not emphasise ensuring that it complements corporate objectives or the need for managers to be made aware of projects being conducted. Additionally, consumer involvement is not identified as being of particular significance. However, the main purpose of *Making Audit Work* is to provide a framework for conducting audit and therefore the need for local adaptation is encouraged. Indeed, the reference section, which provides worked examples of each stage of the audit project management cycle, includes the performers to facilitate adaptation to local circumstances.

The comprehensive nature and easily accessible style of this booklet make it good value as a practical resource and reference for all involved in audit.

MARGARET THORNLEY
Regional Coordinator for Audit and Quality
KINGSLEY J BURTON
Regional Clinical Audit Manager

Audit: a Manual for Speech and Language Therapists. College of Speech and Language Therapists. London: CSLT, 1993. ISBN 0-947589-02-3.

The practical outcome of a study funded by the Department of Health and coordinated by Anna Van der Gaag, this manual aims at clarifying what is meant by audit and giving practical guidance on how audit can be implemented. Following *Communicating Quality*, published by the college in 1991 and providing a comprehensive guide to good practice and professional standards, ongoing audit activities are seen as essential towards implementing an accreditation strategy by the college.

A framework for audit is given to introduce readers to quality issues and some common problems of measuring quality in healthcare services, audit methods and the rationale for undertaking audit in a changing environment are discussed briefly, and useful references are given throughout.