I am sure that there must be many breast cancer patients like me, particularly those who are still earning, and who do not have blind faith in all doctors, who would appreciate a shake up in the traditional follow up system.

JUDITH HAYNES
132 Main Street,
Wilnecote on the Walls,
Near Loughborough,
Leicestershire LE12 6SZ

I Amelville, A Liberati, R Grilli, T Sheldon.

Quality in Health Care is pleased to receive letters (to be considered for publication) that refer to articles published in the Journal and are from patients or other consumers of health care.

Quality improvement a multiprofessional commodity?
In her editorial in this journal, Alison Kitson raised the following points.
- Of the 498 contributors to this journal over four years, only 28 (6%) are nurses.
- From these figures, it seems that few nurses involved in quality improvement and in multidisciplinary audit initiatives, are submitting their work to this journal.
- Clinical audits are not the involvement of nurses, physiotherapists, managers, or pharmacists significantly outweigh multi-disciplinary audits.

Although I would agree in principle with these comments on the lack of true multidisciplinary audit, I would like to point out that most departments of clinical audit are staffed mainly by nurses and a small proportion of professional audit staff.

The reason for this is mainly economic (audit funding doesn’t run to doctors’ salaries) but what this means, certainly in our trust, is that almost all our audit projects are being designed, carried out, analysed, and presented by nurses. However, in many instances, clearly when it comes to publication, these nurses are credited merely as contributors or as having supported certain projects.

Alison Kitson raised the question of authorship of multiprofessional projects. I think we should promote joint coauthorship in these circumstances. It seems patently unequitable, that one profession, more used to publishing their work, should consistently be credited as lead author, when in most cases the work has been a collaborative effort, with the actual audit, being carried out by other professional groups.

ANNE BUCHANAN
Senior Nurse, Performance, Information, and Audit, West Midlands, University Hospital NHS Trust

Clinical audit and the purchaser-provider interaction: different attitudes and expectations in the United Kingdom
Thomson et al clearly describe the views of purchasers and providers in northern England on the role of clinical audit and its interaction with the contracting process.1 Divisions ran through the boards of purchasers and provider organisations, with very little involvement of purchasers, or even provider managers, in audit. These views have been documented in several studies since the introduction of the national audit programme.2,4 In 1993, during a series of workshops in the South West Thames region, purchaser and provider managers and clinicians expressed a very similar mixture of hopes and fears.5 We now have a reasonable understanding of the barriers to mature shared audit; however, understanding does not seem to be enough. Audit is a victim of wider tensions. The United Kingdom National Health Service has suffered from divisions between professional groups for many years, and more recently, divisions between purchasers and providers. Thomson et al argue for purchaser participation in all audits, to test differences of opinion over audit, but in the absence of trust simple exhortations to cooperate will not be enough. We need to consider the underlying causes of conflict, and tackle deeply ingrained attitudes. In the short term these differences need to be recognised and appropriated organisational structures created.6 It has been suggested that public health may be able to provide a bridge.7 But public health has had limited impact through membership of local audit committees, and to be more effective they need greater integration with commissioning and quality departments within purchasing organisations, while maintaining the support of provider colleagues. Another approach might lie with the non-medical clinical professionals, who tend to have a more positive view of clinical audit,8 but unless they can bring the doctors with them progress will be limited. In the meantime, we need to have realistic expectations and focus on the quality rather than the quantity of shared purchaser-provider audits. Better to have a good number of audits than be successful by all parties, than numerous impractical quality specifications.9 The recommended 40:40:20 split between purchaser initiated, provider initiated, and national and primary-secondary interface audits is a long way off in many places.

JOANNE LORD
PETER LITTLEJOHNS
Health Care Evaluation Unit, Department of Public Health Sciences, St George’s Hospital Medical School, Cranmer Terrace, London SW17 ORE