data enabled generalisation of the methods to other consultations. Chapter two describes the development of measures for needs, process, and outcome. Needs were measured by a preconsultation questionnaire comprising items on physical and social problems as well as the general health questionnaire (GHQ12). Measures of consultation length, particularly mean duration, were used for process. Outcome was measured by a post-consultation questionnaire, part of which was used to produce a mean "enablement" score. The relevant six questions were designed to elicit patients' perceived ability to cope with life and their illness, to understand the illness, to keep themselves healthy and help themselves, and their confidence about their health. An increased enablement score was found to be strongly correlated with increased consultation time at population, practice, and individual doctor level. More complex problems needed proportionately more time for equal enablement.

This seems to be a powerful argument for more time to be allocated to the consultation. Unfortunately, my experience since the 1990 contract suggests that 10 minute appointments are, in effect, reduced to eight minutes by the demands of computer operating and data collection. It also seems as though the patients charter has tended to increase the demand for appointments, such that there is a pressure to revert to seven minutes. I am presently involved in research which suggests that spending more time is beneficial for patients, but do doctors really want to know this?

Is enablement quality and does it make a difference? If the Department of Health can be convinced that it is and it does, perhaps they will provide the resources for general practitioners to do a proper job. It is not yet clear whether enablement is a distinct entity in relation to patient satisfaction. Although the literature will support an argument to regard satisfaction and consultation length as legitimate outcome measures in themselves, a counter argument might be that extra attention and the resulting "feel good factor" are consumer products which do not relate to health outcomes. Professor Howie and his colleagues have recently embarked on a multicentre study which will attempt to consider these issues. For example, enablement will be investigated in relation to the scores on standard patient satisfaction questionnaires, and also health authority performance figures. Enough of this report was stimulating for me to want to persevere with the difficult parts.

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Making Sense of Audit: Second Edition. Edited by Donald and Sally Irvine. (Pp174; £16.50) 1997. Oxford: Radcliffe Medical Press. ISBN 1 85775 119 1.

A main strength of audit in general practice has been to help practice teams manage their work effectively. In these circumstances audit is not regarded as an additional activity to be promoted by enthusiasts or health service structures, but as a part of daily practice essential to the provision of care. Case study seven of the second edition of *Making Sense of Audit* is a clear illustration of this point. The practice realised that it could improve its management of hypertensive patients when a patient who had dropped out of follow up had a stroke. Over a period of years, involving several audits and reference to new guidelines as they were published, the practice was able to manage improvements in care. Eventually, they had installed state of the art computer records giving them instant access to information about their performance.

The role of audit is not confined to the management of chronic disease. In another case study a practice team critically evaluates its approach to making decisions, and over several years reforms itself to ensure efficient planning to meet the challenges of a developing health service. In another, a practice undertook a detailed confidential enquiry after a complaint. This led to review of the practice policy on continuity of care.

When it was published six years ago, the first edition of this book was the best introduction to clinical audit for primary healthcare teams. It has guided many practices to take their first steps in audit and presented the argument that the provision of high quality care required explicit objectives, objective measures of current performance, and systematic management of change to ensure that the objectives are met. Much has changed in the past six years, including the emergence of primary care audit groups, the arrival of evidence-based medicine and the growth of fundholding. The second edition takes these changes in its stride, and even anticipates future developments. As Donald and Sally Irvine point out, change is inevitable and planning is required to ensure that practices can respond and continue to move towards their goals. The first half of the book provides an introduction to audit methods for primary healthcare teams, including the development of criteria and standards, methods of collecting, analysing, and feeding back information, and the management of change. It is written for team members themselves, has a practical style, and avoids excessive detail.

The introduction to audit is helpful, but as with the first edition, the most useful section is that containing 15 case studies of audits from individual primary care teams. The stories convey the truth behind the organisation of audit, show what can be achieved, and highlight the role of audit in practice. Many of the case studies have been updated since the last edition—the practices that undertook them have not stood still. As a result, general practitioners, registrars, and primary care team members will find *Making Sense of Audit* relevant and rewarding. Now we need a version for clinicians in hospital practice.

RICHARD BAKER

Making Sense of the NHS Complaints and Disciplinary Procedures. By D PICKERSGILL, T STANTON. (Pp 196; £16:50) 1997. OXFORD: RADCLIFFE MEDICAL PRESS. ISBN 1-85775-163-9.

The increasing numbers of complaints and lawsuits practitioners face has brought the need for effective management of complaints firmly on the agenda. Some significant changes to complaints procedures in the past three years has provided new responsibilities for staff to deal with the initial stages of complaints and an overview of these structures is welcomed.

In *Making Sense of the NHS Complaints and Disciplinary Procedures* six authors cover 14 topics they have identified as being relevant to understanding the processes set up to handle complaints within general practice. The reader is given a brief overview of the dissatisfaction with the previous complaints procedure and the development of the Wilson Committee's recommendations with particular focus on input from the British Medical Association. The authors then run through the different branches of complaints bodies and processes including local resolution, conciliation, independent review, the role of the ombudsman, disciplinary procedures, the General Medical Council, and others. The areas covered are highly relevant, however, by limiting the brief very tightly to the organisations that react to complaints, the proactive structures that could be used to minimise complaints and litigation and to improve supporting data for effective defense of practice where appropriate are missed. Thus adverse incident reporting is only briefly mentioned and the benefits of integrating complaints with risk management, quality, and audit programmes are excluded.

Potential readers need to bear in mind that the function of the book is to clarify the structures of handling complaints and does not therefore deal in depth with the content of complaints. A reader looking for personal insight into minimising the difficulties of going through any aspect of the procedure or improving on the way they handle the content of a complaint will gain little beyond common sense suggestions—such as listen to patients, keep effective records. There is a surprising dearth of references to published literature and the research that is quoted is not always referenced. Thus a helpful example of a structure that staff might find supportive such as Pietroni and Uray-Ura's patient participation group and some interesting quotes such as "three-quarters of GPs considered complaints to be not at all justified", are tantalisingly unavailable.

Although there are areas of repetition, the book serves as a helpful overview to the function of the different bodies. The text is concise with clearly defined topic areas, and although there is no overall summary or chart about the relation of the various stages and organisations, the brevity of the book makes it possible to quickly get a feel for how they slot together. It offers a useful starting point in getting to grips with the new procedures.

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How to read a paper: the basics of evidence based medicine. By Trisha Greenhalgh. (£ 14:95; Pp 196) 1997. London: BMJ Publishing Group. ISBN 0 7279 1139 2.

When asked to review the book *How to read a paper* I have to admit I was filled with anything but boundless enthusiasm. Then I noted the author and a glimmer of hope appeared. I was not disappointed. Not only does the author's inimitable style shine through her writing, her creative and pragmatic approach to critical appraisal turns a potentially heavy text into a light entertaining and very informative read. This book would, if anything could, inspire the sceptical practitioner to begin to see the importance of evidence based practice and its realistic contribution to making patient care more objective, logical, and cost effective; or facilitate the

converted to develop their skills while providing a comprehensive source of further reference.

Unfortunately the title is misleading in its use of the term "evidence based medicine". This book in reality takes a very multidisciplinary perspective and interprets evidence based medicine as the ability to admit uncertainly and cope with change. The coping strategy being one of identifying and meeting ongoing learning needs while applying knowledge appropriately and consistently in new clinical settings. Any guidance in achieving this is surely appropriate to all healthcare workers ? I think that this book will provide a solid foundation for any practitioner wishing to ask questions about scientific evidence, seek answers to such questions in a systematic way, and alter practice accordingly, fulfilling an explicit aim of the book.

As someone interested in exploring how community nurses make professional decisions in an evidence based way, this book will provide for me a clear structure from which to explore the five main steps towards an evidence based approach to practice. Each chapter ends with a series of exercises aimed to consolidate the information given already. The skills facilitated within these exercises range from the formulation of the initial clinical question, the process of searching the literature (without apology the longest chapter), methodological critique through exploration of the role of guidelines, and implementing change in practice.

The author has obviously condensed the wealth of both her own experience (as a general practitioner in London and senior lecturer) with that of her other contacts and networks within the growing movement in evidence based medicine to produce one of the most readable and practical books on the subject to date.

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