QUALITY IN HEALTH CARE

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LETTER

Purchasing good quality eye care: the provider's view

Vafidis rightly points out that a multidisciplinary team approach to eye care for diabetic patients is necessary.[1] Care for people with diabetes takes place across the primary-secondary interface and we agree that the integrated clinics and outreach provision discussed can be effective.

We must take issue however with Vafidis' confident assertion that "most districts have established a scheme locally which aims to screen all diabetic patients within the area." Would this were the case. We undertook a survey of provision for diabetic retinopathy screening in England and Wales during 1996 as part of an audit sponsored by the Royal Colleges of Ophthalmologists, General Practitioners, and Physicians. We received replies from all 105 health districts, of which 44 (42%) had established screening schemes and a further seven (8%) schemes that had been running for a year or less.

In the 44 districts with established schemes, a total of 54 schemes existed; many of these did not cover the whole population of the district. Of the 54 schemes we identified, 39% were optometrist based, and 32% used retinal photography, underlining Vafidis' point about the importance of multidisciplinary teamwork. Our findings show that fewer than half the health districts in England and Wales were providing population based screening in 1996.

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1 Vafidis G. Purchasing good quality eye care: the provider's view. Quality in Health Care 1997;6:92-8.

DIARY

16-18 April 1998

Vienna, Austria. The 3rd European Forum on Quality Improvement in Health Care. The event will consist of one day teaching courses, invited presentations, plenary sessions, posters, and presentations selected from submissions. For further information please contact the BMA/BMJ Conference Unit, British Medical Association, BMA House, Tavistock Square, London WC1H 9JP. Tel 0171 383 6605. Fax 0171 383 6869. Email 106005, 2356@compuserve.com

BOOK REVIEWS

Effective Procedures in Maternity Care Suitable for Audit. By Angie Benbow, David Semple, Michael Maresh. (Pp 56; £ 8) 1997. London: Royal College of Obstetricians and Gynaecologists Clinical Audit Unit. ISBN 0902331 80 9.

The work involved in reviewing the literature to set standards of maternity care on which to audit is time consuming and may be confusing. So—let the Royal College of Obstetricians and Gynaecologists (RCOG) Clinical Audit's prestigous committee do it for you and read their document.

The committee has produced a succinct, clearly laid out 55 page booklet, predominantly referenced through the pregnancy and childbirth module of the Cochrane Database of Systematic Reviews, which recommends standards for different aspects of maternity care. Each topic has suggested auditable standards, more than 100 ideas to keep your audit meetings busy and interesting. To decide which topics to audit, the authors encourage participation of consumer representation—such as the local Maternity Services Liaison Committee. This will be new territory for many units.

However, although some of the standards would be straightforward to audit, many are vague and would be difficult audits to try and set up—for example, all women should have free access to literature regarding alcohol consumption, or all women should be aware of the results (of their rhesus antibody status) and their importance. Perhaps a subsequent document is required which sets out formats of how to measure such data so that these audits have a greater chance of being performed and could be compared between units (not league tables).

It is likely that purchasers will take on many of these advised standards as they include unit based practice standards—for example, all units offering continuous intrapartum cardiotocography should be able to offer facilities for fetal blood sampling, or a service for external cephalic version should be available. I did not find any of the standards particularly controversial and think that most units will already be working within them.

The number of patient information leaflets which are suggested, although laudable, is daunting and again a central source of leaflets, which can be adapted to local needs, would be useful. The RCOG and Midwives' Information and Resource Service (MIDIRS) have patient information leaflets but at a cost.

There is a section of procedures not included because the medical evidence is not yet very strong. Within this section is that of measuring nuchal translucency as a screening for fetal abnormality—a test often being requested by patients and paid for privately.

I welcome this booklet and it will prove very useful for the obstetric audit coordinator.

FELICITY ASHWORTH
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Clinical Effectiveness and Primary Care By M Baker, N Maskrey, S Kirk. (£ 18.50; Pp 136) 1997. Oxford: Radcliffe Medical Press. ISBN 1 85775 129 9.

Many National Health Service (NHS) strategies have struggled to move from slogan to reality. *Clinical Effectiveness and Primary Care* is about the challenge of not just recognising its value and learning for the task, but doing it in practice—the move from competence to performance.

Maslow's hierarchy of human needs describes how we all try and meet our lower order physiological needs—such as food and shelter—before we move up to giving energy to love and belonging, and then on to curiosity and the search for knowledge. The authors use this as a model to look at the blocks of evidence based practice. From this potentially pessimistic analysis, the book hints at some solutions. Consultants in the past may have won resources for unproved treatments by position and forceful personality. Some general practitioner fundholders have used the same conflict based approach. The authors describe the potential value of evidence based commissioning, as a cooperative activity, meeting not only the higher echelons of Maslow's pyramid, but also the lower processes of belonging and self esteem.

One of the strengths of the book is the background of its authors, from general practice, public health, and NHS management, and recognition of the tensions between these disciplines. The missing author is perhaps the patient. We are told that "As the day of the patient expert beckons, there will be no hiding place for substandard clinical practice." What a wonderful opportunity to use the traditional general practice skills of working with the patient to enhance their understanding and decision making. I have already partnered a patient with a rare condition who wished to be the expert, with the doctor taking the supporting role of mentor, friend, and tutor in critical appraisal!

I greatly enjoyed the book, and found that it stimulated reflection on how to move evidence based practice from a slogan to a reality. I would have liked a little more on the role of qualitative evidence.

I was interested towards the end of the book to read that "In the longer term, General Practice will provide the majority of care which is now delivered in hospitals." Primary care might well achieve this, and it is all the more important that general practice maintains and develops the specialist skills of the consultation and understanding the patient's ideas and beliefs that can allow the patient with their folder of internet printouts to share the role of expert.

ANDREW WILSON
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Measuring Quality in General Practice. Edited by: JGR Howie, DJ Heaney, M Maxwell. (£13.50; Pp 32) 1997. London: Royal College of General Practitioners. (Occasional Paper 75.) ISBN 0 85084 232 8.

What is quality and does it make it a difference? These questions are answered only partially in this fascinating account of a major research project. The authors were commissioned by the Scottish Office to carry out an independent evaluation of the Scottish Shadow Fundholding Project for some marker conditions. Secondary analysis of the

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VOLUME 6 • SUBJECT INDEX

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