sequence of the material is not always logical. However, it does contain a wealth of useful material and will allow a non-expert to understand the key issues and, even more important in the reformed NHS, to use the politically and technically correct language to discuss them with managers.

A number of books on healthcare computing written for a medical audience are now available. This one compares favourably with the competition.

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Hospital names. By Michael Smith and Alex Sakula. Royal Society of Medicine Press, London, 1994. 119pp. £10.00.

Yet once more Alex Sakula astonishes us with his literary output. This time, because of his failing eyesight, he has enjoyed the cooperation of Michael Smith FRCP, and both pay tribute to the late Charles Allan Birch FRCP, another prolific author, for the study on hospitals named after famous people which he began in the last year of his life, and left to Alex Sakula to complete.

It is a study after Alex’s heart, full of fascinating detail, where almost every fact reminds the authors of some other interesting connection. You feel they could have gone on forever, without the slightest risk of boring their readers, but this is necessarily a small book—its publication facilitated by an anonymous donor—and reference to 150 hospitals in 108 pages inevitably means that any one entry is tantalisingly brief. The names are grouped in chapters on ‘Persons of fame’, ‘Doctors and nurses of renown’, ‘Royalty and aristocracy’, ‘Benefactors’, ‘Saints’, and a miscellaneous group of hospitals with intriguingly obscure names.

Many will wish to delve deeper, especially into the history of hospitals where they have worked. All readers are likely to cherish the surviving traces of individualism, all the more as they risk being asked to serve, as in wartime, in hospitals designated as General Hospital No. 15 or District hospital No. 107.

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Stroke audit package. Produced by the Royal College of Physicians Research Unit and the UK Stroke Audit Group. Royal College of Physicians, London, 1994. Introductory booklet, audit form, audit software, clerking proforma. £25.00

The Royal College of Physicians’ Research unit together with the UK Stroke Audit Group have produced a Stroke audit package. Its contributors were mainly experts in the field of stroke care and research, but unfortunately without primary care or rehabilitation input. Consequently the report’s focus is on the audit of hospital care rather than overall care. The aim of the Package is to develop methods for auditing hospital care and to enhance the quality of patient care, although it is not clear how this can be achieved without relating process to outcome.

Evaluation of stroke management and development of stroke services have become growth industries over the past few years since organisations such as the King’s Fund and the Royal College of Physicians turned the spotlight on the deficiencies of these services and the need to develop standards for care in a multidisciplinary manner. The Royal College of Physicians recommendations for stroke management were produced as long ago as 1989 and comprehensively covered the prevention and management of stroke [1]. National recommendations such as these require tailoring to local situations; West Lambeth developed locally auditable standards [2] based on the College recommendations, others described standards for the process of care for patients in hospital [3].

The Package consists of an introductory booklet with instructions on how to perform an audit, the audit software (3.5 inch disk), audit forms with standards incorporated and proformas for clerking patients with stroke. The audit form has been rigorously piloted and although its inter-observer reliability is good amongst medical staff it is not so for others, constraining its use for multidisciplinary audit. The audit form is designed to collect information on which aspects of the history and management of the stroke have been documented. Areas for the audit range from risk factors prior to stroke through clinical presentation to rehabilitation and secondary prevention. The standards against which the documented process is compared are, in the main, derived from King’s Fund consensus statement and the Royal College’s recommendations.

There is no attempt to audit practice against these standards, but merely to check whether certain processes have been documented. The audit attempts to distinguish good from bad care and to provide a more complete picture of how stroke patients should be managed. There is no guidance on how to assess post stroke outcome as the group considered there to be no measures that reflect the quality of care available. Although the relationship between the process of care and resultant disability may not be clearcut, the use of scales such as the Barthel could be advocated to assess outcome generally in relation to service inputs. Of course, survival and complications post stroke could also be considered as markers of the quality of care provided, and confounders such as age, case severity and comorbidities taken into account. The importance of multidisciplinary teamwork is stressed in the package but the standards against which this is to be assessed are not clear.
The booklet includes useful guidelines on how to perform the audit on a random selection of casenotes, the numbers of patients required for the audit of various standards, and how to enter the data and tabulate the results. Areas where performance falls short of the standards and strategies developed to rectify them should form the basis of discussion at stroke audit meetings.

The advantages of the Stroke audit package are that it is a cheap and simple way of introducing evaluation of local stroke services and that the guidelines are clear and the output user-friendly. There is opportunity to compare performance over time and between units, although how one deals with changing standards is not discussed. It allows comparisons to be made between timepoints and significant differences quantified; and it is possible to compare units by sending anonymised data on disk to the College Research Unit for collation.

Its limitations are that only audit process is considered, it is hospital focused and does not reflect stroke care in the wider sense. This is particularly relevant at a time when purchasers of care wish to commission seamless packages across both primary and secondary care, and presumably want all aspects to be audited. Other limitations are that the standards are not locally developed and are medically dominated. One would also expect that such a package, especially the clerking proforma, should be a useful educational tool for staff, but the audit only collects data on whether certain processes were undertaken, leaving clinicians without a dataset containing the clinical details of their stroke population which would allow them to assess the need for stroke services and comparison of practice with locally developed standards.

A more fundamental question that the package avoided, perhaps quite wisely, is the relationship between process of care and outcome. Standardised mortality ratios for stroke vary significantly across Europe, from 78 in France to 199 in Portugal (EU average = 100) and in all countries stroke care consumes considerable health service resources. There are widespread differences in the management of stroke not only within the UK but also within the European Union, both in the medical management of stroke and in the rehabilitation received by patients; eg in Italy patients receive little occupational or speech therapy. Admission rates to hospital vary from 85% in Italy to 55% in some areas of the UK, and the proportion admitted under the care of neurologists rather than general physicians varies considerably.

What differences do these variations in the process of care, and consequently resource use and costs, have on longer term outcome of stroke? A European Union funded research programme, coordinated from St Thomas's hospital, is investigating this relationship in 21 centres in eight European states. All patients admitted to these centres with a stroke have datasets covering areas similar to the College audit package but with details on the use of rehabilitation and primary care services. The difficult, but crucial, element is the collection of follow up data at three and 12 months with outcome assessment, including the Barthel and Rankin scales and the International Stroke Trial questions. The resource implications and costs of different management strategies will be assessed. Protocols will be developed to allow centres throughout Europe to move towards desired treatment packages in the most cost effective manner. The analysis of the use of resources will allow the group to investigate the extent to which variations between centres and the costs of care for stroke are due to differences in the type, volume and the price of care provided. By linking data on resource use and outcome it will be possible to explore the costs and effects of different policies for caring for stroke patients.

The standards of management and rehabilitation of stroke vary and it is likely that the best practices in centres of excellence will have wider application. Audits at a local level using the Royal College of Physicians Package as well as more detailed evaluations assessing the quality of care in different centres will contribute to a better outcome after stroke.

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Pediatric renal transplantation. Edited by Amir H Tejani and Richard N Fine. Wiley-Liss Inc, New York, 1994. 554pp. $99.95.

Children with end-stage renal failure have been treated actively for some 25 years. Initially, major reservations were expressed about the wisdom of treatment, particularly surrounding issues of quality of life, and of growth and development of small children treated long-term with corticosteroids. Treatment is now well established and in the intervening years management has greatly improved. Renal transplantation is a central part of management and this book is a timely up-to-date account of this aspect.