terms of health care management and provision in the decades to come.

One interpretation of the future of general practice is that it is going to follow the lines that other major businesses have followed in recent years. The rapid introduction of change is a result not only of political pressure, but also the realization that a pyramidal structure of management has never worked efficiently and is never likely to work efficiently. Such a structure has led to the managers being distant and isolated from the customer and from the employee or practitioner who actually comes into face to face contact with the customer. In general practice, the customer and client is usually the patient and his or her carers. Thus the management needs to be devolved to that level. The new management system inherent in the development of the new National Health Service and in the securing of its future is that of a series of interlocking management doughnuts†. In the new NHS there is a central management unit consisting of a group of general practitioners and/or their managers. Alternatively the centre may be the family practitioner committee. The central management liaises directly with the consumers of the service through the ill-defined flexible communications it decides upon as best meeting the needs of the managers and the clients. Good local communication ensures that appropriate services can be delivered.

The regional health authorities act as the central managers of another doughnut in which the clients (general practitioners, primary care teams and district services) are linked by the family practitioner committees.

Various other levels of management doughnut may be defined to suit the specific needs of the community. The whole process allows more direct involvement of management with the providers of care and therefore with the consumers.

The district health authorities are changing in that they are no longer the providers and paymasters. Their role is changing initially to being purchasers of medical care from a number of sources and their role is expected to diminish further with time as more and more general practitioners become direct purchasers of services.

The general practitioner, in meeting his or her role of the future, will need to be able to plan and manage his ability to deliver health care — a responsive system will become an accountable system. Those practitioners who feel that they are unable to bear such responsibility will have little choice but to become employers, directly responsible to their paymaster (the family practitioner committee) and delivering selective services only.

Better systems of communication and diversification in the technological side of general practice will allow the general practitioner to manage a disease or illness with little recourse to secondary care. If he does require such help, then he will have the controlling influence over its selection and management. The Department of Health will gradually take more of a backseat in the provision of health care, acting only as a planning unit for long term strategy. The better managed the primary care unit, the more freedom and independence it will achieve.

If general practitioners continue to avoid looking into the future of health care provision, opportunities to develop will be missed and they will find that management will be imposed upon them, both clinically and administratively. We have already witnessed the fallability of our 'contract'.

I submit, in contrast to Dr Sykes, that all practitioners should prepare plans for holding a budget under the proposed practice funding initiative in order that a better balance is achieved when the outcome of the first two year experimental period comes to a close. Failure to take part will result in future budgets being set pro rata to the needs of previously 'successful' practices.

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†A management doughnut is a sphere containing a defined centre of management separated from its outer periphery by a very flexible area. The peripheral surface of the doughnut is the contact with the clients.

Misunderstanding of 'audit'

Sir,

I was somewhat disheartened to see that the *Journal* has added to the confusion surrounding the term 'audit'. The paper by Gillam and colleagues (June *Journal*, p.236) demonstrates the misuse of the term today.

Audit is a cyclical process.[1] Present practice is identified and compared with a standard which can be either implicit or explicit. Action is then taken to alter practice to approach the desired standard. The cycle is completed by reviewing the activity under scrutiny at a later date and assessing the effectiveness of change. The process should be continuous, allowing for steady improvement in practice. Audit can be applied at any level, from individual to hospital.

Gillam and colleagues provide the descriptive background for an audit project and this is correctly identified by the authors as 'this descriptive study ... to examine the reasons for late presentation of congenital dislocation of the hip.' This in itself, however, does not constitute audit.

Audit is a powerful tool to improve the practice of medicine. We should not allow it to be diluted and its fundamental feature of feedback lost.

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Reference

1. Fowkes FGR. Medical audit cycle. *Med Educ* 1982; **16**: 228-238.

Referrals by optometrists to general practitioners

Sir,

I read with considerable interest Dr Peter Perkins' paper on the outcome of referrals by optometrists to general practitioners (February *Journal*, p.59). I agree with his claim that general practitioners filter and direct patients along the pathway between optometrists and ophthalmologists. However, I question whether general practitioners are effective in such filtering. I would like to refer him to an earlier study we conducted where 10% of patients were lost somewhere along this pathway between the optometrist, the general practitioner and the specialist.[1]

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Reference

1. Kljakovic M, Howie JGR, Phillips CI, *et al.* Raised intraocular pressure: an alternative method of referral. *Br Med J* 1985; **290**: 1043-1044.

Benefits of developmental screening

Sir,

Having spent many hours as a community medical officer in unproductive screening of pre-school children, I strongly support Professor Bain's views as expressed in the *Journal* last year.[1] Most of the abnormalities discovered, with the exception of visual and hearing problems, are either irremediable or already recognized or both. Dr Hooper's letter (July *Journal*, p.303) only serves to confirm this opinion.

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Reference

1. Bain DJG. Developmental screening for preschool children — is it worthwhile? *J R Coll Gen Pract* 1989; **39**: 133-135.