though one of the authors, Adam Dakinins, is surely fascinating that “five years from now we will all expect decision support when we look at treatment choices” – ten or fifteen years ago. A workshop on media evaluation and lay participation yielded some very germane points. And improving the communication that takes place through the media is certainly necessary; in May 1994 alone the National Asthma Campaign has had to pick up the pieces of a huge “stereos scare” perpetrated by The People, and explain to caller after caller that “the asthma gene” has not in fact been found. The newspapers would have them believe.

But why does the report have to be so loaded with jargon? Do any of us actually like being called a “healthcare consumer” when we are ill? Why call the conference, “Involving Users of Health Services in Outcomes Research” instead of, “Asking Patients What They Want”? If those who own and deliver care really want patients to help to make themselves better the first thing they need to do is to learn to speak in plain English.

MELINDA LETTS
Chief Executive,
National Asthma Campaign


It might seem imperative to write a review and suggest that we write and talk less about quality, in health care and more about the real nature of the health business so that we can understand more about what really needs to be done. I can disagree with nothing in this book; what concerns me is what it doesn’t deal with and its rather superficial and simplistic analysis of the issues. I doubt its influence on the quality in the service sector (sic).

I just might be shrewd-waving, claiming on behalf of these services, “But we are different ...” You may judge for yourselves, but the notion that health services are analogous, in managerial terms, to making “widgets” or even to Macdonald’s a myth that has been around for over ten years and needs to be put to rest. QM and TQM (you will have to read the book to know what it means) will not address the fundamental issues that an organisation like the NHS is facing; they could help, but not where the business happens. We need to get back to understanding the nature of the health business.

JOHN MITCHELL
Consultant, Mitchell-Damon


Most contemporary nursing courses include instruction in the philosophy and methods of quality assurance. This text is aimed primarily at those nursing students undergoing Project 2000 diploma courses. The text may also be used as an introductory text by nurses seeking to become quality assurance practitioners to take responsibility for the quality of service they provide, the second provides seven factual examples of how the DQI system was applied to practice. The latter can illustrate the potential benefits of what this book offers. If they wish to increase their knowledge concerning other quality assurance approaches in nursing (for example, Monitor, QualiPACs), or read the nonstatistical, computer software or multidisciplinary quality initiatives they will have to look elsewhere.

In conclusion, the authors set out to write a book that introduces nurses to the principles and practices of a quality improvement approach. I believe they have succeeded. They have produced an inexpensive, elementary, and understandable text which should be an attractive purchase for the quality assurance neophyte who requires guidance in an increasingly complex field.

HUGH MCKENNA
Lecturer in Nursing


Sitting down with this book, I recollected a consultation I witnessed as a medical student twenty years ago. A middle aged patient had come for the results of a bronchoscopy done six weeks previously. The physician said, “I’m sorry to tell you that you have incurable lung cancer and there’s nothing anyone can do for you.” The patient gulped and left, and the consultant turned to me and said, “I always find it best to be frank in these cases.”

On the second page, I found a similar experience of bleak helplessness towards the hopeless case described by the authors, and from then on the book rang true. Although based on experience in the hospice setting, this overview of progress in palliative care over the past two decades is helpful and relevant to all those involved in care of the dying in hospital or the community.

Care with terminal incurable illness have various physical, social, spiritual, and practical problems, and the challenge is to relieve discomfort, enhance wellbeing, and foster realistic hope that good quality life may be enjoyed until the end. Carers do not need exceptional counselling or psychiatric skills, but rather sensitivity to the patients needs and wishes, sympathy and the right words. Palliation is sometimes perceived, wrongly, as placebo, but in fact many active measures are available to alleviate distressing symptoms. The management of dyspnoea, for example, includes practical advice – on sleeping upright; using a cool fan; taking drug treatments such as opiates, nebulised bupivacaine; and encouragement to try the unorthodox – diazepam. Common sense helps – cachexia is less of a problem if it is explained that force feeding and focusing on food will merely serve to make the patient uncomfortable, and will not prolong life.

Caring for the population of patients with AIDS presents unique problems, as
Quality Assurance in Nursing

Hugh McKenna

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Updated information and services can be found at:
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