(TQM) and the newer realms of resource management and medical audit. In this respect it is more a book for senior managers and for staff in organisational development, though still of use to clinical staff who want to link their audit practice into the wider context of TQM. It will be particularly useful for those involved in getting quality to play a real part in contracting.

The style is succinct; there are main points to note, steps to take, and models to follow and use to explain the process to others. In fact, at times the style is a little too succinct; I found myself wondering, for example, how the author would deal with the cynicism that often accompanies TQM programmes. The steps he suggests for setting up the programme cover staff involvement, and the chapter on communications is excellent, but I would have still liked something specific on resistance to change and the cynicism that "nothing will change."

But this is a small point, who knows, following Koch's programme to the letter may make resistance a thing of the past. Overall the book is the most practical and useful I have seen on TQM, and it is firmly rooted in the NHS rather than trying to be international, which often results in being relevant to no one. I did, however, find myself gasping at the price, which for 119 pages of A4 seems excessive. Nevertheless, the book is clearly aimed at those responsible for change rather than for professionals implementing their own quality or audit programmes. Set against the cost of bringing in a consultant or that of making errors which cause the programme to fail, this is probably a small price to pay for such a useful programme.

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Medical Informatics. Benson T (pp 138, £60). Essex: Longman 1991. ISBN 0-582-082714.

The title is succinct but what does it mean? Medical informatics is a term commonly used to describe the application of information technology, telecommunications, and computer techniques and applications in medicine and in medical education. This defines the needs of the practising doctor as a prime requirement. In stark contrast to the clinicians' needs, large sums of money are being spent on introducing information technologies into the health service which are designed primarily for use by managers and finance officers. The merit of these systems and their benefit to health care have been seriously questioned.

Against this background a book on medical informatics could be very valuable. The author is managing director of ABIES Medical Information Systems, which he founded in 1980 to develop and market clinical information and medical audit systems that help doctors, nurses, and administrative staff in their daily work. He has also been involved in medical data interchange standards since 1987 and has worked with Dr James Read and others to develop the Read clinical classification. Moreover, he worked with

Rachael Rosser on global health care outcome measures. It is therefore reasonable to expect this book to present the reader with a state of the art discussion of medical informatics with a particular emphasis on the needs of the practising doctor but set in the wider context of health care. The only hint of warning is contained, unfairly in my view, on the fly sheet. Here it states that the book is a report for managers and clinicians.

Hospital information systems, resource management systems, CASEMIX systems, and other systems have been primarily developed from the perspective of administration. Systems that are of particular value for doctors in their clinical work have been developed only by enthusiasts and, unfortunately, have not been commonly accepted. This partly reflects the difficulty of the subject of medicine and partly the fact that the medical profession has been slow in realising the need for investment of time, energy, and money and, more particularly, in establishing liaisons with departments of information technology, medical informatics, or operational research, to enable clinical systems to develop. The management, financial, and other needs can be met from these systems, which are primarily developed for the practising clinician; the needs of doctors cannot be met, and never will be met, by systems developed for management purposes.

Medical Informatics falls into four main parts. The first section introduces the central role of information and communications in health care and sets out the predictable consequences for health care computing of the new internal market. The second section describes some of the main functions for which computers are used. The third, which perhaps might have been the most interesting for the critical clinician, covers key subject areas in health care computing, including classification and coding, outcome measures, and standards for medical data interchange and quality of data collection.

Frustratingly, in the first chapter the author identifies that future investment in health care computing needs to be directed more towards providing tools for clinical management and support and less towards simply providing data for service managers. Unfortunately, he fails to involve and excite the reader about this potential and gives no hint of the future.

The book is very valuable in the overview that it gives to the development of computing and information technology and health care. Many terms that are perhaps unfamiliar to the reader are well explained, as are issues relating to the new internal market in health care in the United Kingdom, to networks, and to privacy. The description of the various management related systems is useful for understanding their intent and, perhaps more importantly, their limitations. In particular, it emphasises the problems associated with the "blind" collection of data without much thought to how the vast volume may be turned into useful information.

The advent of general practice computers is described in fairly positive terms. In fact, a golden opportunity was

lost; there was an ideal chance to develop and implement an innovative strategy for information technology in the primary care environment which would have been of use to practising doctors as well as to administrators. This missed opportunity reflects the parsimonious and narrowminded approach to information technology typical of health care in Britain. This is contrasted with the radically different view adopted by the European Community with funded projects such as AIM (Advanced Informatics in Medicine) and ESPRIT (European Strategic Programme of Research in Information Technology).

The chapter on outcome measures is extremely limited. Since this is perhaps one of the more important topics that need developing in health care it is sad that the approach is superficial. In contrast, the chapter on medical coding and classification is excellent. The development of the Read code is not only interesting and informative but is also the most comprehensive clinical coding system in widespread use and has the huge advantage of being able to transcend the primary and secondary care interface. Electronic data interchange and the open systems interconnections are well covered and give the manager and clinician some understanding of the issues. Any discussion of expert or advisory systems is omitted nor does the book mention any of the newer developments which may change the whole face of information technology.

Medical Informatics describes the development of medical informatics up to the present; for the sum of £60 the reader might reasonably expect to be given more insight into future developments. The book addresses too wide an audience and might have been better if it had focused either on the manager or on the clinician. It has fallen into the trap of satisfying neither.

DAVID PATTERSON
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MEETINGS REPORTS

Quality is the key ... British Association of Medical Managers (BAMM) conference, Eastbourne, June 1992

Two views of this meeting appear below: the first is that of a non-medical chief executive of a hospital trust and the second is that of a medical manager.

Eastbourne. The taxi driver volunteers apropos of nothing and within seconds of leaving the station, "We're not all geriatrics in Eastbourne you know."

Although most of the delegates were middle-aged white men, there were more women than there would have been ten years ago at a gathering of doctors on management teams.

The BAMB conference was a refreshing and uplifting event, which was striking for the genuine enthusiasm of the delegates for their emerging organisation. There were the strong swirls of opinion that new formations generate before they become hidebound by convention and their own little traditions. I doubt that the members of the association will have to put on white gloves to vote in their president.

The delegates seemed to have come to the conference to get down to work, and the well attended sessions quickly generated discussions from the floor. As a non-medical manager, I had been invited to talk about the expectations that chief executives would have of medical managers. Some delegates seemed disappointed with my number one requirement – personal integrity, a quality well distributed in the audience and much undervalued by those with it. Delegates were looking for the “golden fleece” – managerial technique. They felt keenly their inexperience but were mostly people who had already succeeded in getting on in a fiercely competitive environment.

One of the case studies was a typical management trap: a bundle of half relevant facts and clues with a request for a decision. A horse race bet. Like so many management decisions, a free guess between two choices, yes or no. The answer comes through hindsight. Some delegates betrayed their scientific origins by a strong instinct to use the deductive process and a reluctance to guess. I later saw the same case study tackled by personnel managers, who were untroubled by the lack of evidence and delighted to stick in their personal opinions.

Signs of budget phobia were diminished but still visible. Medical managers make financial management into a psychologically daunting challenge and remain, on the whole, easy meat for old lags in the treasurer's department when it comes to being twisted on their budgets. However, given the number of doctors coming into the game and the willingness to learn shown at the conference, there will be few years left for finance departments to forget to mention inflation if the clinical director forgets first.

I did not catch the outcome of the internal debate about letting other professions join as members – I hope that the association remains mainly a grouping of doctors. The separate training and late entry to management brings about problems but also a clearly different perspective to the management culture of the NHS, which has a danger of becoming a bit stuffy and administrative. The Trust Federation should encourage all of its medical managers to join the association, and I commend next year's conference to them all.

ANDY BLACK
Chief Executive,
Central Middlesex Hospital
NHS Trust

The theme “quality is the key ...” attracted an impressive array of involved clinicians to the second annual conference of the British Association of Medical Managers, and the quality of the meeting was clear from the full turnout of delegates to all the sessions despite the rival enticements of Eastbourne during a heatwave.

Opening the conference, Sir Roy Griffiths reviewed the introduction of general management into the health service and emphasised his view that it was a means towards providing a quality service. The current reforms, by clarifying accountability, were a further move in this direction, and he expressed a strong belief that they needed to involve doctors in order to achieve the ideals of the health service. Professor Kakabadse then gave a masterly exposition of the characteristics and executive skills found in successful leadership teams, and the opening session concluded with a wide ranging panel discussion about the clinicians' roles in management, which illustrated the wealth of practical experience already acquired and indicated some useful evolutionary patterns for the future.

Workshop sessions dealing with medical management in general and quality in particular occupied a day and a half of the meeting, and they were particularly illuminating for those clinicians previously regarding medical audit as the main index of quality and health care. The concept of the flat, empowered organisation, seeking continuous improvement in quality at all times, at all levels, and aiming primarily for consumer satisfaction, was emphasised throughout. The necessity for top management to talk with and to train its people to aim for zero defect, “to work smarter not harder,” and to remember that everyone is a customer and a supplier emphasised themes in quality management familiar to other organisations and which the health service is slowly coming to terms with. The sessions on good communication methods, essential in introducing a quality approach, were particularly valuable; the necessity of focusing the service on patients and of using multiple methods of assessing patient satisfaction were emphasised. The pursuit of quality implies major significant and continuous change within the service, and the effects of such change and strategies for coping with it were discussed in the closing address by Professor Carnall. Clarity of vision by top management with the ability to channel the undoubted creativity of the workforce towards achieving that vision was the key for success.

The feeling as the conference closed was that change which is continuous and leads to better quality is now an inevitable part of the NHS. In future we will hear less of “what the doctor ordered” and more emphasis on “the customer is king.”

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Association for Quality in Healthcare (formerly National Association for Quality Assurance in Healthcare) annual conference, Solihull, May 1992

The main messages of this two day conference, whose theme was “The Quality Transformation: Designing the Future of Healthcare,” were about organising for quality, better communication, and a more customer/client oriented system.

Introducing the conference, Nancy Dixon, chairperson of the association, encouraged a redesign of approach to meet current and future challenges, enhanced by addressing the patient/client experience, by empowerment, and by staff support programmes.

Kate James described the objective of the NHS Management Executive, which is to create a better NHS by ensuring that services are of the highest quality and responsive to the needs and wishes of patients, relatives, and friends. She explained how the executive intends to achieve this by ensuring that quality is a central issue; through the patients' charter; and by disseminating good practice, setting standards, and changing the culture to create a more patient focused service.

Jonathan Boyce described how the role of the Audit Commission has been primarily to focus on value for money but that this must be set in the context of consumerism, NHS reform, professional self audit, and quality. He listed the weaknesses in the NHS in terms of quality activities as isolation, focus on easy measures, underrepresentation of patients' views, and the lack of appropriate evaluation mechanisms. The commission, he said, could contribute to quality improvement as an independent organisation providing a comparative overview, even though it had a short term record in health care. It could help to bridge the perceived gap between theory and practice in quality.

At the hard end of health quality lies litigation. In a thought provoking account of risk management Geoffrey Roberts of the Medical Defence Union emphasised the importance of the four s's – speed, sympathy, satisfaction, and say sorry – in dealing with complaints procedures. Perhaps 80% of complaints involving medical care might be avoided, reducing the £180m a year incurred in litigation costs.

Deborah Harman, quality and training adviser, South East Staffordshire Health Authority, reviewed BS5750. This standard specifies the requirements for quality systems designed to generate products and services which meet the agreed specifications within an organisation. She gave a balanced account of the merits and demerits of the approach and reiterating that the effect of BS5750 quality systems is to ensure consistency – and reliably good or reliably bad services! Questioning whether the NHS is ready to work to BS5750, she raised the issue of confidentiality of medical records, which is difficult to resolve satisfactorily for all parties.

Another external accreditation system is the organisational audit process. As