of the Assistance Publique – Hôpitaux de Paris. Her book brings together a summary of the concepts, methods, and experiences of the evaluation of hospital medical care from the British and American literature, relating it to the emerging practice of medical audit in France.

It seems that a widespread culture of quality assurance in medicine is even less in evidence in France than in Britain despite the passage in July 1991 of a law obliging hospitals, private and public, to develop programmes to assess and guarantee the quality and efficiency of care. The French National Agency for the Development of Medical Evaluation (ANDEM), established in 1990, had an annual budget of under £9m, compared with the £50m a year allocated for medical audit in Britain since 1989. As well as seeking to stimulate the enthusiasm and allay the suspicions of the medical profession, the book is a plea for the adequate resourcing of audit in both material and human terms.

Dr Giraud's tour of the literature falls into three parts. The first presents evidence on the variability of medical practice, the factors underlying it, and the disciplines – clinical epidemiology, decision support, medical audit – needed to minimise the random and subjective nature of much that doctors do. The second outlines techniques for the evaluation of care – the audit cycle, the organisation of audit within hospitals, the development of guidelines, the importance (and rarity) of adequate information systems, the choice and problematic nature of outcome measures. The third describes some important examples of audit in practice. All this is not as dry as it sounds; the book is not an exhaustive textbook of audit but more an invitation to get excited about the challenge of practising better medicine – while acquiring some basic intellectual furniture for the task.

A recurring theme in the book is the need to resolve the ambiguity between audit for improving care and audit for limiting costs, and the consequent need for the independence of medical audit agencies from purchasers. We are reminded of the evidence that simple budgetary restriction limits necessary as well as unnecessary uptake of health services – which we are seeing ample evidence of here in Britain this winter.

Points of cross cultural interest emerge more from little details than from the main themes. A footnote explains for a French readership the meaning (in the protocol for the Confidential Enquiry into Perioperative Deaths) of the term "waiting list." The lack in France of a source of uncontested medical authority comparable to the British royal colleges presents a problem of one kind, while the serious shortage of nurses, precluding their participation in data collection and audit, presents another. A plea for more importance to be attached to clinical competence and less to research output in determining medical career progress strikes a familiar chord.

This book would, I think, fill a gap in the English audit literature – if it were in English! It was a pleasure to read, and in lieu of some tedious graphic of the audit cycle it has a beautiful drawing by Andrea del Sarte on the cover. Alexandra Giraud finishes by pointing out that we know so little about what makes a "good doctor" that we are obliged to put the expression in inverted commas. We really need to find out more.

DUNCAN KEELEY
General Practitioner

Health Service Quality – An Introduction to Quality Methods for Health Services. Ovretveit J. (pp 186; £12.95). Oxford: Blackwell Scientific Publications, ISBN 0-632-03279-0.

The NHS reforms have stimulated a major heightening of the profile of quality in a relatively short period. The separation of purchaser and provider and the internal market have introduced an ingredient of competition (previously missing) that has allowed providers to focus on improving quality as a major selling point to their customers. The application of other "business" practices has contributed to the growing debate about how to manage quality in the NHS. This has included offering power to customers through a national consumer charter, a plethora of consultants and academics extolling the virtue of total quality management (TQM) and other quality improvement systems, and the influence of both non-executive directors from outside the NHS and an increasing number of executive directors undertaking MBAs all seeking to change the culture.

There are several set texts on TQM but few considering its applicability to the health service and attempting to link the various elements of the usually uncoordinated hospital quality assurance activities. Ovretveit does not package his book as a "guide to TQM," though he does refer to TQM briefly as one approach to consider. But what he describes and the way he constructs his argument is, in my opinion, a TQM approach. His book will be essential reading for chief executives and directors committed to improving the quality of service. In most hospitals there are pockets of excellence often influenced by enthusiastic individuals. In very few is this harnessed through a strategic approach to managing quality, seeking to empower all staff to continually improve the service.

Ovretveit seeks to link the quality programme with business strategy and marketing and concedes that many will be surprised by this approach. He also suggests that client quality, professional quality, and management quality need to be integrated and offers a quality management cycle, with tools to measure each aspect. Such concepts will meet with even greater resistance from many used to unidisciplinary, "professional" internal monitoring. His advice to start slowly and avoid antagonism by seeking ways to demonstrate how staff can benefit from

improving quality should be heeded by any chief executive embarking on the major culture change needed. Indeed, the emphasis given to the crucial input of staff is most appropriately emphasised by Christina Townsend, NHS training director, in the foreword, where she comments that the quality programme will not succeed if "the necessary attitudes, skills, and working relationships go largely ignored and underdeveloped." On accreditation, which is again firmly on the agenda, with the King's Fund's organisational audit programme and BS5750 vying for attention, he observes that other countries have not experienced high quality health care through this process.

The book is easy to read and well structured and its conclusions are backed by interesting practical examples. It is perhaps ironic that the only example of a TQM or coordinated quality approach is the Wel Qual framework from the United States. What is the progress in the national TQM demonstration sites in Britain? One year on, there should be more progress to report.

Ovretveit concludes that quality requires a systematic approach; that responsibility for quality lies first and foremost with management (in my opinion specifically chief executives); and that the importance of a balance between people and processes and between systems and relationships should be recognised.

A chapter is devoted to the cost of poor quality. Improving quality will (eventually) save money. The NHS must be increasingly bold about reducing the cost of quality and challenging the myth that massive resources are needed to improve quality of services.

This book has influenced my thinking considerably, and it will make a significant contribution to the quality debate.

STEPHEN RAMSDEN
Chief Executive

Developing Teamwork in Primary Health Care: a Practical Workbook. Pritchard P, Pritchard J. (pp114; £10.50 pb). Oxford: Oxford Medical Publications, 1992. (Practical Guides for General Practice No 15.) ISBN 0-19-262204-8.

Primary health care teams do not just happen, they need to be created, supported, and sustained in order to be effective in delivering quality health care. The assumption, all too often made, that placing various professional and other workers in the same team will result automatically in their working together well is rather like believing that if one throws all the delicate cogs and wheels, the internal mechanisms of a watch, up into the air they will land in perfect alignment and the watch will immediately start ticking. Although much attention has been given to invoking primary care teams to work well together, practical guidance on how to achieve this has been less forthcoming. However, *Developing Teamwork in Primary Health Care* goes a long way to addressing this problem. It is

exactly what it sets out to be, an excellent practical workbook, one of a series of practical guides. Its small size makes it less daunting for hard pressed primary care team members who want to improve their teamwork but find it nearly impossible to create enough protected time to meet and learn together. The text is easy to read, "user friendly," and separated into manageable sections, with clear objectives enabling a sense of achievement at each stage. The aim is that each section could be covered in a one hour team meeting, with short explanations of various aspects of team development to be read before the meeting and small pieces of "homework" to enable individuals to reflect on the team and their role in it before discussion with the whole group. The instructions for the homework and for running the meetings are in the main both clear and precise and would, I believe, enable many teams to run their own meetings without external facilitation. The descriptions of team development theory are skilful summaries from what is clearly a wealth of management experience, indicating the authors' expertise in making such complexities accessible without them becoming meaningless generalities. I particularly liked the explanation of conflict in the section on "Working in a Team," the helpful guidance on time management, and the practical group exercise on the induction and welcome of new team members. The section on team leadership is sensitively covered with a non-threatening but thought provoking team exercise. Sections progress logically through the book focusing on goals, tasks, roles, and procedures rather than getting deeply into values, beliefs, and personality clashes, which, although important, are hard to deal with effectively within most teams and can easily sabotage team-building progress. The authors avoid "doctor bashing," a potential trap when examining reasons for team dysfunction, and neatly display their own knowledge and experience of primary care by using illustrations and insights which teams will immediately identify with.

Organisational development theory is so extensive that individuals working in this sphere necessarily develop preferences for certain management models and beliefs about the "essential" components of successful management and therefore are easily critical of others using different models and theories. Nevertheless, I believe that there are gaps in this book. Although the introduction includes "general hints for conducting exercises," these focus on practical issues such as time and room space. There is no mention of ground rules or agreements about how participants would like the meetings to be – that is, that they are treated with respect, that contributions are valued, and that there are agreements about confidentiality. In my experience such ground rules are very helpful in building group "safety," such that people are able to think clearly and contribute honestly without fearing humiliation or exposure. The authors do state that "the leader will need to ensure that members are in the best possible frame of mind to be open with one another" but without specific guidelines leaders might not have the facilitative skills needed to achieve this.

Teams need to be able to evaluate their progress, celebrate their successes, and review any difficulties. Although there is a section in the book called "Evaluation of Teamwork," it is rather disheartening, with an overemphasis on the difficulties of such evaluation; I would have preferred a greater focus on identifying team achievements and what *can* be done to evaluate teamwork. The final section "The Way Forward" could have been much more detailed, with specific guidance on developing and agreeing action plans, including time schedules, deciding responsibilities (who does what), and review processes so that teams can keep up the momentum of teamwork development.

Despite these few critical observations I highly recommend this constructive book to any primary care teams wishing to develop their teamwork and also to facilitators and others who may be involved in the fascinating task of helping teams to work together well.

NICKI SPIEGAL
Primary Care Facilitator

Designing a Fair and Reasonable Basic Benefit Plan using Clinical Guidelines. California Public Employees' Retirement System (PERS), Deborah A Lott, ed (pp 115; free). Sacramento, California: California PERS, 1992. ISBN 0-9633681-0-9.

In April 1991 a conference was held in California to debate the approach to setting guidelines for the services that should be included in a basic package or benefit plan for health care. The basic benefit plan is meant to provide all necessary preventive, diagnostic, and therapeutic interventions and the associated guidelines are required to specify the clinical indication for which specified interventions would be deemed necessary for insurance coverage. The suggested definition for necessary care proposed to the conference was "services that, in the judgment of the panel, have been 'reasonably well demonstrated to provide significant net health benefit.'" Health benefit was further defined as being the life expectancy and quality of life improvements expected from the intervention minus any expected negative consequences, including any risk of death or of unpleasant and dangerous side effects. The procedure therefore uses an assessment of expected outcomes by an expert panel to determine whether or not a specific health intervention should be included in a basic health insurance package.

The conference was facilitated by the provision of a model proposal as to how these necessary care guidelines would be developed, and the immediate aim was to give guidance to the California Public Employees' Retirement System, which currently has a health benefits programme available to 800 000 people in California with an annual premium volume of \$1.1 bn.

The published proceedings make a valuable contribution to the debate about guidelines and rationing, not least because of the participants, who include many of the good and the great of American

medicine – for example, Robert Brook, David Eddy, Alain Enthoven, Robert Kaplan, and Kathleen Lohr. The format is unusual in that the presentations by the speakers have been reduced to brief summaries whereas the discussion is recorded in some detail. This unusual style does, I think, turn out to be worth while, given the quality of the discussions. For example, we learn from Robert Brook that the cost of developing a guideline could be as high as between \$250 000 and \$500 000. One member of the audience, reporting that the United States health system was now consuming 12.2% of the gross national product and the figure was still climbing, commented, "Of course we still have 88% to go". The audience was well aware that the rate of inflation in health care is rising in the United States at twice that of general inflation. An interesting exchange took place over the level of care that should be included within the basic plan. One of the proponents of the scheme (David Hadorn) said he would be willing to have his health care governed by 95% of what is covered in the basic plan and so retain the opportunity of opting for treatment outside the plan to cover specific preferences. This made clear some of the difficulties about devising a plan based on necessary care. The delegates struggled with the moral question of refusing to provide care to patients that could not be absolutely justified in terms of health benefit, but they were unable to reach a satisfactory conclusion. There will always be patients who feel so desperate that they are willing to undergo treatment that does not have a widely accepted outcome benefit. There will also be experimental treatments that have not yet come into wide use. These and other situations in which the outcome of specific treatments have not been clearly established present difficult choices to insurers, physicians, and patients.

The conference seems to have continued over several days, and towards the end of the proceedings I found that there were elements of repetition as participants came and went. Some of the later sections could have been reduced, although this may reflect more my own interest in general issues that can be applied to the United Kingdom, rather than specific matters unique to the American health care system.

The concept of the basic benefit plan shares some of the objectives of the Oregon experiment, although in Oregon attempts were made to include the valuations of the public, and it was also a state initiative for Medicaid benefits. The Oregon approach was criticised because the priority list of 714 items make little allowance for the fact that for any given treatment there are both high benefit and low benefit patients. More detailed guidelines might overcome the blunt instrument of the Oregon list. The conference proceedings have made clear to me that the development of guidelines is inextricably linked with the movement towards rationing in health care. There is some interesting discussion whether the savings generated by guidelines accrue because inefficient, unnecessary, and wasteful care will be reduced or whether guidelines should be developed that take