British medical literature comes from general practitioners. Good, because general practitioners, at whom most guidelines are targeted, have generally been insufficiently involved in their production. As guidelines proliferate (an estimated 20 000 are already in circulation in the United States) all doctors need to learn how to appraise them critically. Who produced them? What for? How did they do it? How was the published evidence searched and checked for quality? Is the evidence on which the guideline is based applicable to the population of patients to whom the guideline is going to be applied? These issues are discussed, and an appendix contains a handy checklist "draft appraisal instrument" for looking in the horse's mouth.

Doctors worry about the medicolegal implications of guidelines. "In the United Kingdom," the report reassures us, "it seems safe to infer that the mere existence of ... guidelines is unlikely to influence the course of an action for medical negligence unless the guideline concerned is so well established that no responsible doctor, acting with reasonable skill, would fail to comply with it." A handy checklist for deciding whether a guideline is "well established" is not provided.

Although the resources for developing guidelines based on irrefutable evidence are likely to be available only nationally or regionally, a sense of ownership within each team or unit is needed for the best chances of implementation. A procedure for implementing guidelines within a practice is described, but it sounds a bit dull and likely to generate only a token sense of ownership. The exciting agenda is for general practice to get more actively involved in the interrogation of evidence. As in the rest of the NHS, information technology in general practice is oriented too much towards administration and underused in pursuit of the knowledge needed to treat patients better. Practices need to get wired up to the Medline and judge the evidence themselves, which will be more motivating – and more conducive to improved patient care – than the sequential discussion of 20 000 guidelines on how to do our work.

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Primary Health Care, A Prognosis. Maria Duggan (pp 79; £7.50). Institute for Public Policy Research, 1995. ISBN 1 86030 0006.

As the National Health Service undergoes metamorphosis from being dominated by secondary care to being led by primary care those working in primary health care are experiencing extraordinary upheaval. It is just possible that primary care will emerge from this revolution some time towards the end of next year, but perhaps I am being over optimistic. Rather like a

Victorian explorer, Maria Duggan has courageously ventured into this potentially alarming territory and in this book reports on her encounters with the "natives".

The investigation took place in three health authority areas and in each a variety of primary health care staff were interviewed, including general practitioners, directors of primary health care, fund holding managers, directors of nursing, directors of public health, district nurses, and others. The methodology is not fully described and it is not clear how those who were interviewed were identified; nor are the interview schedules described in detail or the methods of data recording and analysis discussed. Although the methods were probably completely acceptable, it would have helped to have had more detailed information. For example, it would have been useful to have been told how recently the interviews took place.

Nevertheless, despite this, the report does clarify the current stresses and strains experienced by those working in primary health care. The text is liberally sprinkled with revealing quotations from the people concerned. There is an almost equal balance between positive statements pointing to the advantages of changes such as fund holding and the many opportunities that are now becoming available, and more anxious or uncertain comments from those unable to cope with the pace of change and uncertain that any real benefits are being brought about. Surprisingly, one general practitioner is quoted as saying that "multi-agency collaboration is the key to practising in disadvantaged areas," and perhaps this suggests that barriers between professional groups are at last breaking down. However, the overriding impression from the interviews was of the critical views that each sector involved in primary health care holds about the others. There were general practitioners critical of health authorities and social services, but there were also directors of nursing who were critical of general practitioners and wished to see reform so that they could buy in general practitioner services. At the same time there were also directors of social services who found cooperation with health authorities and general practitioners inadequate.

The prescription Duggan offers is the emergence of local units or agencies with the responsibility for purchasing. This is not a particularly new idea, but the details of how such agencies might be managed are new. Various models are allowed, including agencies which are commissioners but not providers of primary care services, and those which can be nurse led, manager led, or general practitioner led; all are meant to be leading to a genuine partnership between doctors and nurses. Perhaps this recipe is the right one. However, as a general practitioner I am not entirely sure. The district nurses still visit my patients at home and tend them with as much care and efficiency as they ever did. My patients still visit the surgery with more or less the same com-

plaints, the same infections or pains both physical and emotional, I still have to telephone the hospital to find out why outpatient appointments have not materialised as requested or to phone social services and chivvy them into action on some patient's behalf. I know that staff in the different sectors speak different languages and think in different ways – for example, to social services the term "urgent" means sometime in the next two weeks but for me it means drop everything and run. Perhaps the reason why many of the general practitioners in this report do not seem to be team players is because in comparison with the unchanging pattern of clinical work, changes to service organisation seem to be much ado about nothing. Until the link between organisation and outcome can be made as explicit as it is for new treatments or health technologies the importance of organisational change will always seem to be peripheral in the eyes of clinicians.

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A Classification System for Nurses' Work Methods. Gerald Bowman, David Thompson, eds (pp 77; £95). Oxford: National Institute for Nursing, Centre for Practice Development and Research (Report No 9), 1995. ISBN P1-898537-00-6.

The reality of the best and worst interactions between nurse and patient is well documented in this booklet along with painfully accurate descriptions of common forms of nursing care. The use of a "nursing work" classification system is proposed as a tool to assess objectively, whether nurses on general wards use primary nursing, team nursing, or task allocation.

The classification system is apparently unique but Bowman and Thompson admit that, as a tool, it is crude and requires refinement. This booklet contains two outline case studies of recent applications of the classification system as a tool for auditing. Disappointingly there is little new information from the original authors. Two journal articles by the authors from 1991 and 1993 are reprinted forming about 20% of the material contained within the booklet.^{1,2} These reprints explain the theoretical, philosophical, and historical context of the classification system.

Quality is referred to infrequently but is the implicit rationale for the classification system. McMahon (currently Royal College of Nursing adviser for research and development) writes about quality being related to consistency and continuity in care planning. She explains almost step by step how "named nurse" quality standards, in a nursing development unit in the John Radcliffe hospital, were monitored with Bowman and Thomson's classification system.

Adair and Murray make a case for an opportunity to discuss discrepancies

between a commitment to primary nursing and pressurised reality. The comparison and criticism of three tools for auditing organisation of care is documented. Although some criticisms of the original classification system of Bowman and colleagues are cited, it survives, they argue, as by far the most useful tool currently published for classifying primary nursing activity.

The brevity of this booklet is frustrating. Although the tool looks eminently sensible it would be hard to imagine nursing advisors making use of it without further validation. The report's reference list infers that Bowman and Thompson have not further researched the tool. Despite being a 1995 publication, there is surprisingly only one reference cited after 1993.

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- 1 Bowman GS, Thompson DR, Webster RA. The development of a classification system for nurses' work methods. *Int J Nurs Stud* 1991; 28:175-87.
- 2 Bowman GS, Meddis R, Thompson DR. An item analysis of a classification system for nurses' work methods. *Journal of Clinical Nursing* 1993;2:75-80.

How to do it: vol 1, 3rd ed. Edited by Deborah Reece (pp 272; £12.95). London: BMJ Publishing Group, 1995. ISBN 0 7279 08480.

It is a common wish to do things well or better. It is satisfying to undertake something in a new area and feel confident. So I read this book with interest and expectation. It covers a wide range of topics under the headings of management, employment, and counselling and it is worthwhile speculating how quality in health care could be improved by following the book's advice.

In the management section I was particularly impressed with the chapter on "Being a dictator." This has clear advice on how to use a dictating machine and a secretary. These are skills that all doctors need to streamline the work load and, therefore, improve the accuracy and timeliness of correspondence.

The practical chapter on "Sign post your hospital" must have a major impact for patients. It seems a small thing, but there is nothing worse than wandering around the corridors and searching for hospital departments in a state of anxiety and apprehension, to be faced with incomprehensible signs, or worse, no signs at all.

The employment section is full of useful advice. In particular, the idea of job shares for consultants' posts is an important addition. Dissemination of this advice could lead to an increase in the number of consultants, more balanced lives for them, and hence an improvement in the quality of patient care.

The most interesting parts of the book are the chapters on counselling. Doctors are usually compassionate; unfortunately,

they do not all possess the skills necessary to show this compassion. With this in mind, the chapter on "Handling uncertainty, collusion, and denial" is excellent. What a difference to patients it would make if all doctors read the examples and became skilled in the ways described. Also, the section on "Broadening your mind about death", given our pluralistic society, should be compulsory reading for every final year medical student. If this were so, some unintentional distress caused to the bereaved would certainly be prevented. This book should be available in every hospital library and postgraduate centre. Reading it could only improve the quality of patient care, both directly and indirectly.

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Research Methods and Audit in General Practice. 2nd ed. David Armstrong, John Clare (pp 218; £25.00). Oxford: Oxford Medical Publications, 1995. ISBN 019 262454 7.

It is generally assumed that general practitioners are less likely to initiate research than doctors working in other disciplines. There are probably various explanations, including pressure of work, professional priorities, and the general practitioner's preoccupation with each patient rather than groups of patients with the same disease. Nevertheless, research publications by general practitioners and other researchers working in primary health care are steadily increasing. There may be many potential general practice researchers who have encountered difficulties in taking their first step into a research project because of the lack of sources of advice or support.

The aim of *Research Methods and Audit in General Practice* is to provide sufficient practical guidance for potential researchers to complete and publish a project. Thus, an enormous range of issues is covered, from identifying questions for research, study design, and data analysis to a chapter introducing the computer programme Epi Info. Nevertheless, it is impossible to cover every subject in detail in a book of this size – for example, the use of statistics is compressed into a single chapter.

The book is particularly strong on qualitative research methods, but there are no references to further reading. This would have been helpful to guide further studies of statistics or the epidemiology of study design as these were not discussed in any depth. The brief chapter on audit could perhaps have been omitted, although given the present importance of clinical audit, discussion of the relation between research and audit is certainly appropriate.

Although the authors have included so much, the book remains not only comprehensible but also enjoyable to

read. I managed to finish the book in spare moments in a single week thanks to the clarity of the text. Each chapter is supplemented by exercises and questions for the reader, important devices which encourage careful thought about the topics. The book is successfully aimed at the beginner, so would be of value to general practitioners beginning research, general practice trainees who are undertaking projects, or junior researchers working in general practice.

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An Evaluation of Nursing Developments in Continence Care. K Williams, B Roe, F Sindhu (pp 190) Oxford: Centre for Practice Development and Research, National Institute for Nursing, 1995. ISBN 1-898537-07-0.

At a time when the mastery of technical skills is becoming increasingly valued in nursing, this report is a grim reminder of the inadequacies of the profession in managing a core nursing issue and a very sobering read.

About three million people in the United Kingdom have urinary incontinence, a profoundly distressing problem which may severely affect their physical, psychological, and social wellbeing. Among older people urinary incontinence is a more complex issue with a multifactorial aetiology and it therefore poses a great challenge to nursing in terms of assessment and management.

The National Institute for Nursing is to be commended on its research for this report in this very neglected aspect of nursing. *An Evaluation of Nursing Developments in Continence Care* is exactly what this report sets out to achieve. Divided into eight sections reflecting the different stages of the research process, the report provides a comprehensive and critical review of research published between 1983 and 1993, with an accompanying table of a brief overview of prevalence studies.

As well as the literature review, the research had three distinct objectives: firstly, to prepare research based guidelines for nursing practice in the form of a clinical handbook for continence care; secondly, to assess the acceptability of the clinical handbook to practitioners; and, thirdly, to evaluate the dissemination of research guidelines for continence care. The project used a static group comparison design involving a pre-test, post-test, and follow up approach. The study involved two groups of nurses: an experimental group who received the intervention, which comprised a focus group and the use of the *Clinical Handbook for Continence Care* (Roe and Williams 1994), and the control group who did not receive the intervention. Although a potential population of 433 qualified nurses were invited to participate in the study, 54% attended the first session, of whom 29% actually completed