Nevertheless, a positive attitude for continued participation in the audit process was achieved, and we ultimately found the experience rewarding and educational.

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Jennifer's ear: airing the issues

Dr Nick Black's editorial¹ illustrates the disingenuousness of those seeking to confirm their prejudices. The case of Jennifer's ear has little to do with the provision of services for otitis media with effusion (OME) (glue ear). Her father recently explained that her problem was one of recurrent tonsillar infections for which she needed adenotonsillectomies,² and that treatment of her ear condition was not of prime consideration. To base criticism of the current management of OME on this case is unwarranted.

The Effective Health Care bulletin advocates what practising otological surgeons already do in most instances for uncomplicated glue ear; those who ignore the current literature from their surgical peers^{3,4} are unlikely to be convinced by a paper from non-clinicians. The performance of adenoidectomy as a day case is certainly feasible and the paper by Yardley⁵ considers this, but to say he has questioned the need for inpatient care is to overstate his conclusions. The audit to 1991 showing that many health districts fail to carry out grommet insertions as day cases⁶ probably illustrates the shortcomings of data retrieval in the NHS at that time, since it has been impossible to separate those cases having grommet insertion as a single procedure from those having more extensive surgery such as adenotonsillectomy. For Black to suggest that had day case treatment been advised for Jennifer, she need not have waited for her operation is to confuse the length of an inpatient waiting list with the availability of day case surgery. Day case surgery requires exactly the same amount of operating time and surgeon availability and depends critically on access to an appropriate bed. Day case surgery does not necessarily eliminate waiting times and indeed may prolong waiting if day care facilities are limited.

The aspect of management of glue ear that remains largely ignored is the time it takes to see an otologist and to get reliable audiometry performed. This is in large

measure a reflection of the paucity of paediatric otolaryngological services.

By the time most children are seen they have had established glue ear for a considerable time and have undergone a period of unwatchful waiting. Better and quicker access to competent audiometric assessment in a properly soundproofed environment is a prerequisite to better diagnosis and supervision of the hearing loss.

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- 3 Maw AR, Herod F. Otoloscopic, impedance and audiometric findings in glue ear treated by adenoidectomy and tonsillectomy: a prospective randomised study. *Lancet* 1986;i:1399-402.
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- 5 Yardley MPJ. Tonsillectomy, adenoidectomy and adenotonsillectomy: are they safe day case procedures? *J Laryngol Otol* 1992; 106:299-300.
- 6 Audit Commission. *All in a day's work: an audit of day surgery in England and Wales*. London: HMSO, 1992. (NHS occasional paper, No 4.)

AUTHOR'S REPLY - Putting aside the particular diagnosis which prompted the political debate, I do not in any way alter my views of the current management of glue ear, which remains an area of public and professional concern. The Audit Commission, which performed the audit of day surgery in 1991, was well aware of the shortcomings of the hospital episode system and therefore did not rely on it, as explained in the report Mr Bull quotes.¹ One of the several advantages of day surgery is that it is considerably cheaper than inpatient care. The resources released can be redeployed to reduce the time patients are currently having to wait. One use of such resources could be audiometry services, thus reducing waiting times for investigations of middle ear functioning.

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- 1 Audit Commission. *All in a day's work: an audit of day surgery in England and Wales*. London: HMSO, 1992. (NHS occasional paper, No 4.)

Clinical audit project

The clinical audit project is concerned with the development of audit in four therapeutic professions: clinical psychology, occupational therapy, physiotherapy, and speech and language therapy. Commissioned by the Department of Health, the work is being carried out by experienced social science researchers and policy analysts in health studies from two units: Maurice Kogan and Tim Packwood from the Centre for the Evaluation of Public

Policy and Practice, Brunel University, and Sally Redfern, Sarah Robinson, Ian Norman, and Anémone Kober from the Nursing Research Unit, King's College, University of London.

The aim of the project is to work with the four professions to develop and evaluate a set of models on which their audit activities could be based. The models are likely to contain components specific to each profession as well as a common core, and they will constitute a logical development of the work undertaken by Professor Charles Normand and colleagues that advocated a common framework for audit in these four professions.¹

The project's current phase - interviewing key people with knowledge of audit in these professions, selecting case studies, and devising interview schedules - is almost complete. The next phase will comprise, for each case study, interviews with people in each profession who are involved in audit activities and with members of other professions or groups whose work may impact on these activities. The data will be analysed to identify generic and specialist principles and components of audit and those issues in which there is agreement or disagreement within and between the four professions. The aim will be to produce a detailed set of draft models for audit practice for discussion with the professions.

Any enquiries about the project should be addressed to Anémone Kober, Nursing Research Unit, King's College, Waterloo Road, London SE1 8TX (tel 071 872 3060/3057; fax 071 872 3069).

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BOOK REVIEWS

Evaluation Médicale des Soins Hospitaliers. Alexandra Giraud (pp 210; Ffr 250). Paris: Economica, 1992. ISBN 2-7178-2335-2

Alexandra Giraud wants hospital doctors in France to take charge of the evaluation of medical practice rather than submitting to it as an external constraint. Medically qualified, with degrees in politics (Paris) and public health (Yale), she was responsible from 1987 to 1990 for the Service for the Evaluation of Health Care

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.

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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.

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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