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 a graphic of the audit cycle it has a beautiful drawing by Andrea del Sarto 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


The NHS reforms have stimulated a major realignment 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 “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 external and internal monitoring systems, and the importance of 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 translated into a more systematic 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 conceives 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 enthusiasm from many used to undisciplined, “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 the human factor has been 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 undermined.” On accreditation, which is again firmly on the agenda, with the King’s Fund’s organisational audit programme and BS7750 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 Wael 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 represents a realistic 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 internal and external 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


Primary health care teams do not just happen, they need to be created, trained, and sustained, and in some contexts are 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 in the air they will land in perfect alignment and the watch will immediately start ticking. Although much attention has been given to involving 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 the therapist to review, and its primary purpose is to build a foundation in the appraisal of practice. The authors demand the patient's knowledge, skill, and ability, and there is a clear rule-out section. The instructions for using the workbook are skilful summaries from which it is clearly a wealth of management experience, indicating the author's expertise in making such compromises. In cases of significant importance, 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 advice on the induction and welcome of new team members. The section on team leadership is sensitively covered with a non-threatening but thought provoking technical procedures. The practical exercises are through the book focusing on goals, tasks, roles, and procedures rather than getting deeply into values, beliefs, and personality clashes. These are important, and are hard to deal with effectively in a small team and can easily sabotage team-building progress. The authors avoid “doctor bashing,” a potent trap when elaborating cases for team dysfunction. They try to neatly display their own knowledge and experience of primary care by using illustrations and insights which will immediately identify with the reader.

The occupational development theory is too extensive that individuals working in this sphere necessarily develop preferences for certain management models and beliefs about the “essential” components of success 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 as respectful and cordial, that contributions are valued, and that there are agreements about confidentiality. In my experience such ground rules are helpful in building a “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 “Evaluating Teamwork,” it is rather disheartening, with an overemphasizing of 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 for 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


In April 1991 a conference was held in California to consider the approach to setting guidelines for 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 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 Employee’s Retirement System, which currently has a health care benefits program available to 800 000 people in California with an annual premium volume of $1.1bn.

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 worthwhile, 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 a similar type of 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 to go outside the plan in order 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 what it would mean to provide care to patients that could not be absolutely justified in terms of health benefit, but 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 widespread 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 latecomers who could barely follow the discussion 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 validation of the public’s share of state initiative for Medicaid benefits. The Oregon approach was criticised because the priority list of 714 items made little allowance for the flexibility of the plan. The chosen 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 also attempted to teach 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