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BOOK REVIEWS

Portfolio Based Learning in General Practice. Pietroni R (pp 35; £9.00

This occasional paper has been published at an opportune time for reassessing the learning model and opportunities both for doctors undergoing vocational training and for established general practitioners to obtain more value from continuing medical education than merely the collection of postgraduate education allowance points.

The document focuses on the use of adult learning principles so often ignored in traditional medical education and highlights that the learning experience requires involvement, should be enjoyable, and ultimately should lead to improved patient care. The current failure generally of the postgraduate education allowance mechanism is highlighted, and the meaning of portfolio based learning is clearly described, particularly focusing on the difference from merely keeping a log of activities attended to evidence of the learning that has taken place. Recognition of portfolio based learning as a demanding exercise and the need for regional advisers and clinical tutors to be flexible in granting postgraduate education allowance approval for the work of portfolio based learning are points well made. The role of mentors is emphasised, and the problems of the current lack of current skills in mentoring, the time required, and the likely absence of extra funding are explicitly recognised. Issues of assessment are rather ducked; they remain difficult. The role of the portfolio as a valuable formative tool is recognised, but whether submitting a portfolio will or should remain voluntary is not addressed nor are the training requirements of postgraduate education allowance approval. It could also be a means for other specialties to develop their own continuing medical education.

BRIAN TOMS
General Practitioner


Liaison is probably one of the most important factors between psychiatrists and general practitioners. The common misunderstanding about what both groups have to offer. Psychiatry and General Practice Today provides an up to date source book. The four sections of the book, context, clinical problems, psycho-social management, and training and research contain chapters written by a psychiatrist or general practitioner with a special interest in psychiatry.

Exploiting the relationship between general practitioners and psychiatrists, the book reflects on how GPs can offer their services and the different models of care provided by psychiatrists, such as primary care clinics and crisis intervention services, etc. There is also an interesting chapter, well illustrated with examples, on law and ethics and what is required of doctors regarding power of attorney and court of protection. The second section will find GPs on familiar ground, looking at clinical topics such as alcohol, bereavement and on the whole, it is interesting to consider whether the decision support systems which allow precise consultation time to be used for decision making rather than information sharing are certainly an interesting idea,


We live in an information-hungry age. The role of the expert is increasingly seen as that of facilitator, rather than dictator, of individual behaviour, and this applies to the relationship between patients and doctors as much as anywhere else. Questioning the doctor’s wisdom is, however, something that tends to go on outside the consulting room: “They never seem to listen to me,” grumbles the patient. If only patients would challenge the doctor at the time—in most cases a constructive discussion would ensue, and they would take some informed decisions about treatment. Of course, for that to happen patients need doctors to invite challenge and discussion. Many doctors would probably be very amenable—after all, why waste precious time on repeated consultations to say nothing of money wasted on drug treatments wrongly used, if talking for 15 minutes about the condition and the pros and cons of treatment could remove all that? But the time just isn’t available in a GP’s appointment book and the grumbles go on.

But Will It Work, Doctor? is a report of a conference on an exploration of outcomes research at the King’s Fund Centre in November 1993, which explored ways of creating communication between patients and their carers, and, on the whole, it is interesting to consider whether the decision support systems which allow precise consultation time to be used for decision making rather than information sharing are certainly an interesting idea,
though one of the authors, Adam Darkins, is surely fantasising that “five years from now we will all expect decision support when we look at treatment choices” – ten or fifteen years ago. A workshop with a modicum of lay participation yielded some very germane points. And improving the communication that takes place through the media is certainly necessary; in May 1994 and the National Asthma Campaign has had to pick up the pieces of a huge “stAREs scare” perpetrated by The People, and explain to caller after caller that “the asthma gene” has not in fact been discovered and the newspapers would have them believe.

But why does the report have to be so loaded with jargon? Do any of us actually like being called a “healthcare consumer” when we are ill? Why the conference, “Involving Users of Health Services in Outcomes Research” instead of, “Asking Patients What They Want”? If those who commission and deliver care are really worried that patients want to help to make themselves better the first thing they need to do is to learn to speak in plain English.

MELINDA LETTS
Chief Executive, National Asthma Campaign


It might seem important to write a review and suggest that we write and talk less about quality in health care and more about the real nature of the health business so that we can understand more about what really needs to be done. I can disagree with nothing in this book; what concerns me is what it doesn’t deal with and its rather superficial and simplistic analysis of the issues. I doubt its influence on the quality in the service sector (sic).

For this try and explain why. John Macdonald is right when he questions the reluctance of the service sector to learn the lessons from the manufacturing sector. What is less clear is whether he also appreciates and values the distinctiveness of the service sector. It seems to me that by grouping financial services, the civil service, retail trade, local authorities, the transportation industry, the NHS, management consultants, education, and hotel and catering together in this apparently haphazard way he fails to demonstrate the essential nature of these very diverse and the organisations that support them. This is not to say that each should learn from each other, just as each should learn from the manufacturing sector, but that simply transferring learning without a reason is wrong.

Two obvious organisational issues differentiate public service industries – the health service; education; social services; and the media – from private sector industries. first there is a permanent dilemma in trying to meet the needs of the individual and the wider community simultaneously and second the service that people receive depends on the relationship between a professional – doctor, teacher, social worker, prison officer – and the individual user. These issues make the simple translation of methods that are effective in other sectors fail in these unique public service industries. A third issue, the prevalence of institutionalised care – the “stereotypes” of these public service industries, adds yet another dimension. Anyone who has worked in a hospital, a home for older people, a school, or a prison will be deeply aware of the problems of institutionalisation on users and staff alike.

NHS readers of this book will be wary of the paucity of its analysis of the nature of health care and rightly sceptical of the clumsy solutions. Anybody who has read the Ritchie report into the treatment and care of Christopher Clunis will understand readily that while TCI (see below) will keep a lot of people engaged in time consuming activity it will hardly address the profound and endemic problems that pervade all the services that are designed to support, care for, and treat people with ill health.

I just might be shroud-waving, claiming on behalf of these services, “But we are different . . .” You may judge for yourselves, but the notion that health services are analogous, in managerial terms, to making “widgets” or even to Macdonald is a myth that has been around for over ten years and needs to be put to rest. If QED and TCI (you will have read the book to know what it means) will not address the fundamental issues that an organisation like the NHS is facing; they could help, but not where the business happens. We need to get back to understanding the nature of the health business.

JOHN MITCHELL
Consultant, Mitchell-Damon


Most contemporary nursing courses include instruction in the philosophy and methods of quality assurance. This text is aimed primarily at those nursing students undergoing Project 2000 diploma courses. It may also be used as an introductory text for qualified nurses who wish to develop an awareness of standard setting and audit. The core content of the book principally centres around the theory and application of the Dynamic Quality Improvement (DQI) system (formally DYSSSY) as formulated by Kitson and others. Students from other healthcare disciplines may find the book a useful introduction to the DQI system.

There are several other texts competing for this market niche. However, they invariably are broad in their description of the various quality assurance approaches available in nursing. In contrast, this book demonstrates the “why and how to” of a well researched quality improvement approach with its strength. In other merit includes the simplicity of its description and the fact that all chapters contain explicit learning outcomes and study activities. Anybody who intends to make the patient uncomfortable, and will not prolong life.

Caring for the population of patients with AIDS presents unique problems, as