years the scheme affords an invaluable directory of different types of operations, enabling surgeons and others to compare results and morbidity. As yet, despite our recommendations similar schemes have not been developed in other regions. The cost is £60 per joint replacement.

As the number of joint replacements increases so the requirement for revision of joints already replaced will increase. Revision surgery is more complex and more expensive than primary joint replacement surgery. We need to plan for the future revision rate. Centres which have accepted patients for revision surgery are now becoming overwhelmed by referrals. To quantify the need for revisions of hips and knees more information is required about the outcome of joint replacement and it is imperative that new types of prothesis are properly evaluated in appropriately designed and conducted trials. There is no place for occasional, uncoordinated trials of new prostheses. Only by comprehensive coordinated national surveys and audit we will be able to obtain accurate information. Purchasers and orthopaedic surgeons need to work together to establish systems to enable the collation of the requisite data to create a strategy for future provision of joint replacement services. The cost is small compared with the total costs of joint replacement surgery. Not to invest in this now would be a false economy.

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- 1 Ivory JP, Summerfield J, Thorne S, Lowdon IMR, Williamson DM. Total hip replacement. *Quality in Health Care* 1994;3:114-9.

BOOK REVIEWS

Portfolio Based Learning in General Practice. Pietroni R (pp 35; £9.00 (£9.90 non-members)). London: Royal College of General Practitioners, 1994. (Occasional paper 63.) ISBN 085084 1917.

This occasional paper has been published at an opportune time for reassessing the learning needs 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 pronounced 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 the assessors. Personally, I am concerned at the references towards supplying portfolios of learning for higher degrees as this seems to detract from the overall function of personalised learning and realistically will not be attractive to the vast majority of general practitioners.

Finally, there is an excellent chapter on portfolio learning in vocational training, which gives an admirable summary, relevant not only to trainees undergoing vocational training but to experienced general practitioners wishing to participate in meaningful continuing medical education. This chapter alone makes this commendable document worthwhile reading for all general practitioners who have an interest in maintaining and developing their knowledge and skill base. It is not just for the academics or tutors and throws down interesting challenges to regional advisers for postgraduate education allowance approval. It could also be a model for other specialties to develop their own continuing medical education.

BRIAN TOMS
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Psychiatry and General Practice Today. I Pullen, G Wilkinson, A Wright, D Pereira Gray, eds (pp 383; £17.50 paperback). London: Royal College of Psychiatrists, 1994. ISBN 0-902241-50-8.

Liaison is probably one of the most important factors between psychiatrists and general practitioners. There is often 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, psychosocial management, and training and research contain chapters written by a psychiatrist or general practitioner with a special interest in that topic.

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 schizophrenia. Each chapter enlightens the reader with something new; I found the appendix to the chapter on older people, with its abbreviated mental text scale on geriatric depression, particularly user friendly. The section on psychosocial management looks at communications and teamwork, and also includes two chapters – on counselling and on psychotherapy and cognitive behaviour therapy. General practitioners would certainly be able to apply the chapter on cognitive behaviour therapy in practice. Within the training and research section it was interesting from a general practitioner's viewpoint to see how psychiatrists in training view attachments to a practice. Practical guidelines were given on how to look at videos, especially for group teachings.

The book has several strengths. The different authors write with enthusiasm but self-critically and in their individual styles. The chapters are cross referenced, and the references are up to date. *Psychiatry and General Practice Today* is a convenient book to dip into, and I would recommend it to anyone with an interest in mental health issues.

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But Will It Work, Doctor? M Dunning, Gill Needham, eds. London: Consumer Health Information Consortium, 1994. ISBN 1-898300-03-8.

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 treatment not properly 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 involving consumers in 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 encouraging. Video decision support systems which allow precious 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, maybe. A workshop on models of lay participation yielded some very germane points. And improving the communication that takes place through the media is certainly necessary; in May 1994 alone the National Asthma Campaign has had to pick up the pieces of a huge "steroids scare" perpetrated by *The People*, and explain to caller after caller that "the asthma gene" has not in fact been found, as 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 call the conference, "Involving Users of Health Services in Outcomes Research" instead of, "Asking Patients What They Want?" If those who organise and deliver care really want patients to help to make themselves better the first thing they need to do is to learn to speak in plain English.

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But We are Different ... Quality for the Service Sector. John Macdonald (pp 213; £16.95 hardback). Didcot, Oxfordshire: Management Books, 1994. ISBN 1-85251-131-1.

It might seem impertinent 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 quality in the *service sector* (sic).

Let me 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 various industries 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 will have little impact.

Two obvious organisational issues differentiate *public service industries* – the health service; education; social services; and others, like the prison and probation services: 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 that characterises 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 effect 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 cheery 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 mental illnesses.

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 Macdonalds is a myth that has been around for over ten years and needs to be put to rest. TQM and TCI (you will have to 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
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Quality Assurance in Nursing. Heather Marr, Hannie Giebing (pp 139; £9.95). Edinburgh: Campion Press, 1994. ISBN 1-873732-04-X.

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, and here lies its strength. Its other merits include the simplicity of its descriptions and the fact that all chapters contain explicit learning outcomes and study activities for the reader.

The book is divided two parts: the first focuses on what quality is and how nurses can assure and improve quality, placing considerable emphasis on empowering

practitioners to take responsibility for the quality of service they provide, the second provides seven factual examples of how the DQI system was applied to practice.

Potential readers must be acutely aware of what this book offers. If they wish to increase their knowledge concerning other quality assurance approaches in nursing (for example, Monitor, QualPACs), or recent developments in quality assurance computer software or multidisciplinary quality initiatives they will have to look elsewhere.

In conclusion, the authors set out to write a book that introduces nurses to the principles and practices of a quality improvement approach. I believe they have succeeded. They have produced an inexpensive, elementary, and understandable text which should be an attractive purchase for the quality assurance neophyte who requires guidance in an increasingly complex field.

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Palliative Care in Terminal Illness. 2nd ed. J F Hanratty, I Higginson, eds (pp 128; £12.50). Oxford: Medical Press, 1994. ISBN 1-85775-030-6.

Sitting down with this book, I recollected a consultation I witnessed as a medical student twenty years ago. A middle aged patient had come for the results of a bronchoscopy done six weeks previously. The physician said, "I'm sorry to tell you that you have incurable lung cancer and there's nothing anyone can do to help you." The patient gulped and left, and the consultant turned to me and said, "I always find it best to be frank in these cases."

On the second page, I found a similar experience of bleak helplessness towards the hopeless case described by the authors, and from then on the book rang true. Although based on experience in the hospice setting, this overview of progress in palliative care over the past two decades is helpful and relevant to all those involved in care of the dying in hospital or the community.

People with terminal incurable illness have various physical, social, spiritual, and practical problems, and the challenge is to relieve discomfort, enhance wellbeing, and foster realistic hope that good quality life may be enjoyed until the end. Carers do not need exceptional counselling or psychiatric skills, but rather sensitivity to the patients needs and wishes, sympathy combined with pragmatism.

Palliation is sometimes perceived, wrongly, as placebo, but in fact many active measures are available to alleviate distressing symptoms. The management of dyspnoea, for example, includes practical advice – on sleeping upright; using a cool fan; taking drug treatments such as opiates, nebulised bupivacaine; and encouragement to try the unorthodox – diazepam. Common sense helps – cachexia is less of a problem if it is explained that force feeding and focusing attention on food will merely serve to make the patient uncomfortable, and will not prolong life.

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