popularity analysis. A most useful tool is the ability to produce cross tabulation tables and reports. Pinpoint includes a useful range of graphs which can be a powerful tool for presenting raw data or information from subgroups, categories, or cross tabulation reports. Bar, pi, line, and scatter (including regression line) charts are available, which can be annotated with text.

We have found that this program has saved vast amounts of staff time by reducing the need for repeated searches through raw data when information on subgroups or categories is requested or the data need to be presented in another format.

Data can be imported using dBase, Paradox, and comma or tab separated value (CSV, TSV) formats. This allows data already collected on other databases or spreadsheets to be used or information collection on Pinpoint to be analysed in more detail with a statistical package. Pinpoint has a clean interface that is not cluttered with "never to be used" features and we have found this package extremely easy to use and helpful for medical and clinical audit.

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Since this review was written a major new release of Pinpoint for windows is available, details from Longman Logotron (tel 01223 425558).

BOOK REVIEWS

Shared Care for Diabetes. P M Greenhalgh (pp 35; £9.00 (£9.90 non-members)). London: Royal College of General Practitioners, 1994. (Occasional paper 67.) ISBN 0-85084-204-2.

About 2% of the population of the United Kingdom has diabetes and evidence suggests that the incidence is rising. A general practitioner (GP) with an average list size of about 2000 patients will have 25 to 35 patients with diabetes registered in his or her care, of whom about a third will be using insulin. It is essential that GPs with an interest in this condition – and 90% of practising GPs in the United Kingdom are now claiming chronic disease management fees for diabetes management – are familiar with the condition; aware of complications; and have an effective, structured method of care. Thus this review of the various methods of diabetes care is essential and extremely topical.

Although there is no actual original research, Dr Greenhalgh has methodically and brilliantly collated all the original work on shared care for diabetes, has

extensively reviewed all the differing methods of care, and looked at educational and clinical methods. Her work extends back to the mid-1960s, thus including a historical aspect, yet projects forwards with ideas for future development and research. This work has been drawn from many sources ranging from recognised diabetes journals to general medical journals and general practice journals, but the outstanding aspect must be the enormous amount of personal communication that Dr Greenhalgh has undertaken with general practitioners and recognised leading experts, in the United Kingdom and abroad, and thus this occasional paper truly represents the current state of art of diabetes care.

Towards the end a concise chapter summarises the findings and makes recommendations for effective diabetes care in general practice. Dr Greenhalgh comments that effective diabetes care is "achieved only if the system includes a register, protected time, a practice nurse with diabetes experience, a written management and educational protocol agreed with the local consultant diabetologist, and a system for auditing standard of care." She makes the most important point that unstructured care by disinterested primary healthcare teams is ineffective and wasteful of resources. The nine recommendations are intended as guidelines for workers, particularly those in primary care, and, together with the published guidelines for clinical monitoring and the requirement for chronic disease management programmes, should enable most interested practitioners to establish effective and efficient diabetes care.

This paper occupies a very important position on the bookshelves of all staff involved in diabetes care and I am sure will become the authoritative work on shared care for diabetes.

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Quality Assurance in Nursing Practice. N Kemp, E Richardson (pp 165; £11.99). London: Butterworth Heinemann, 1995. ISBN 0 75062326 8.

For those nurses who are actively involved in quality assurance this book will tell them little that is new. However, I suspect that such people are not the targeted audience. Rather this book seems to be aimed at those nurses who are at an early stage on the quality assurance learning curve. In particular it will be a useful source for nursing students on P2000 and undergraduate degree courses.

The first edition of this text, published in 1990, sold well. Many new governmental and professional initiatives about quality improvement have taken place since then and the authors do a good job updating the reader. This is one of several

such texts published this year – all of which seem to be aimed at a similar readership. However, I detect important differences which may give this book an edge over its competitors.

The authors try to unravel the differences between quality assurance and audit, competently using the scientific literature to support their stance. They are less successful in how they deal with "total quality management" and its relation to quality assurance. None the less, the text is full of useful practical examples from a wide range of health authorities and trusts around Great Britain. There is a particularly good section on the various methods that may be used for standard setting and audit and the book gives the impression that the authors have pinned their allegiance to Donabedian's structure, process, and outcome approach, particularly as adopted by the Royal College of Nursing.

Although it deals briefly with multi-professional audit this book essentially focuses on nursing and the nurse's role in quality assurance. Neophytes from other professions may learn much about the theory of standard setting and audit but I would have difficulty recommending it as a suitable text for non-nurses.

I was interested in Kemp and Richardson's subtle issues relating to quality of care (not always found in mainstream texts). These include the relation between research and quality assurance, ethical issues relating to monitoring quality, criterion maps, the effects of manpower on quality, and the practicalities of facilitating and educating practitioners to become actively involved in quality improvement initiatives.

In conclusion, the authors have succeeded in producing an easy to read British text aimed at introducing readers to quality assurance and audit. Those already familiar with these issues will probably not purchase this book but this should not deter them from recommending it to students and colleagues who are less well versed.

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Development and Implementation of Clinical Guidelines. Edited by the Royal College of General Practitioners (Report of Clinical Guidelines Working Group) (Report from General Practice Number 26) (pp 34; £11.00). London: Royal College of General Practitioners, 1995. ISBN 0 85084 207 7.

Guidelines are gift horses into whose mouths we had better look. That is the key message from the general practitioners whose deliberations are summarised in this report. It is good to see that the most thorough appraisal of development and implementation of guidelines in the

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