British medical literature comes from general practitioners. Good, because guidelines, 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 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 provided.

Although the resources for developing guidelines based on irrebuttable 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.

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 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 literally 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 commissioning bodies who provide services, but those which can be nurse led, manager led, or general practitioner led, all acting to lead 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 little regard to their efficiency, as they ever did. My patients still visit the surgery with more or less the same complaints, 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 chivy them into action on some patient’s behalf. However, 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 these problems persist is that staff 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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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 efficiency, 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.13 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 Thompson’s classification system.

Adair and Murray make a case for an opportunity to discuss discrepancies