

be a local collaborative activity. Academic departments of general practice can design or adapt guidelines in consultation with other academic or hospital departments and FHSAs and medical audit advisory groups. FHSAs need to be responsible for supporting practices to help practitioners cope with the increased time required for structured care. Purchasers and regional health authorities need to ensure funding for local initiatives, and departments of public health should set priorities for guidelines according to local epidemiological factors and health needs assessment.

To evaluate the effect of guidelines suitably large studies are required to detect changes in process and outcome measures. These studies should be restricted to answering questions about effectiveness; local projects on guidelines will need to be audited to ensure that their content and implementation fit local conditions. In addition, clinical care guidelines as part of service development require understanding of how change happens as well as being grounded in evidence that procedures are effective. This relies on action research and audit. A simple notion of guidelines as intrinsically virtuous and necessarily improving the quality of care is irresponsible.

The current enthusiasm for general practice guidelines and other clinical guidelines is not matched by a commitment to evaluating their effect on practice. Evaluation should have a high profile within the NHS research and development strategy, and it needs national and regional coordination.

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BOOK REVIEWS

Assessing the Quality of Health Care. Richard P Wenzel, ed (pp 512; £58). Baltimore: Williams and Wilkins, 1992. ISBN 0-68308-924-2.

A glance at the newspapers or medical literature of any rich, technologically advanced Western country is enough to make it clear that its systems for the provision of health care are in a state of turmoil, if not chaos. The reasons are fairly clear, though the solution is not. After our successes in controlling the major infectious killers we have been much less effective at getting to the root cause of the diseases which have taken their place, notably ischaemic heart disease, stroke, cancer, diabetes, and the rest. We have made some inroads into their prevention and have become extremely effective at patching them up

with expensive high technology intervention. Because of, or despite these activities there is an unpredicted increase in the numbers of non-too healthy old people in our populations.

No Western system of health delivery seems to be able to cope with increasing costs of health care. In Great Britain the government's reaction has been to impose one reform after another on the NHS, each one demanding greater efficiency. The latest reform was designed to improve efficiency by trying to make a clear cut division between purchasers and providers. One of its major shortcomings was that, like so many of its predecessors, it failed to define its goals and objectives in a way which would allow them to be compared with previous approaches to the organisation of health care. In this sense it was a badly designed experiment. But one of the major problems in this field is that the scientific basis for trying to assess the quality of health care, which is what health provision is all about, is extremely primitive. It is essential, therefore, that progress is made in the important aspect of medical practice, so that in the future adequate pilot studies can be carried out before massive reorganisations of our health services are undertaken, without any clear evidence that they will work.

These messages have certainly not been lost on those who are trying to improve the quality of health care in the United States. For this reason the publication of this new book, edited by Richard Wenzel, is of great interest. He has amassed nearly fifty authors and has covered every aspect in considerable detail. The opening sections put the problems into historical perspective and then deal with the thorny question of how to define and measure the quality of health care. The historical chapters give an extremely balanced view of the problems of health care in the United States, but when we get to those which attempt to get to grips with the assessment of health and illness we run into a mound of frightening acronyms and jargon, some of which will be particularly heavy going for British readers. The book ends with a series of chapters which describe approaches to assessing quality in many different subspecialties of clinical practice.

Many of the chapters in this comprehensive book are extremely dense and heavy going. But, overall, it is a thorough and balanced review of the current state of the art in the extremely difficult area of assessing the quality of health care. Although it gives an American perspective, says nothing about systems in other parts of the world, and ignores the developing world completely, those who are involved in trying to assess the quality of health care, whatever their specialty, should try and persevere with it. It does not provide many answers, but it offers several interesting new approaches which should undoubtedly be explored within the British system.

Biological systems are extremely complex; sick people are certainly no exception. Alvin Feinstein pointed out recently that we do not yet have the

statistical methods for tackling many of the types of problems which we encounter when we try to assess outcome and the quality of clinical care. But we have to try, and those who are involved in outcomes research, medical audit, or in simply trying to improve the service to their patients in their role as providers should be grateful to Dr Wenzel; he has done us a great service by bringing together this group of authors and providing such a useful baseline on which we can develop our thoughts.

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Curing Health Care. New Strategies for Quality Improvement. Donald M Berwick, A Blanton Godfrey, Jane Roessner (pp 315; £22.50). Oxford and San Francisco: Jossey Bass, 1990. ISBN 1-55542-294-2.

Four years ago, when I started leading sessions for doctors on quality there were two common (mis)conceptions: that quality equated to the technical competence of the medical practitioner and that quality services could be achieved only with additional resources. The conclusion is obvious: doctors do a good job and with more money it would be better! Fortunately time has moved on: quality, avoided and marginalised in the mid-1980s is now everyone's business again, and some – the more adventurous – are welcoming the participation of patients and users in the quality debate.

Hospital managers too are, quite rightly, becoming more rigorous in their considerations of quality, and *Curing Health Care*, a report on the national demonstration project on quality improvement in health care, comes at a fortuitous moment. Its strength is in the sound understanding the authors have of the nature of organisations and the change process. It shows how Berwick's philosophy of continuous quality improvement or total quality management¹ should be applied.

The need for sound management, leadership, visions, values, clarity and purpose are emphasised by the authors. There is a reassuring understanding that blaming is counterproductive ("fix the system, not fix the blame"), that there is a need to work outside formal structures, and that we are dealing with complex problems with no "quick fix" solutions. Further, the book acts as a manual, telling stories of how things were achieved and contributing helpful methods: process flow diagrams, brainstorming and cause-effect diagrams, data collection forms, Pareto diagrams, histograms, scatter plots, and so on, which will help people to engage in the work constructively.

However, like all exciting things, I would counsel a little caution. For example, as the authors readily admit, none of the examples quoted impinge on medical practice and, though changing practice is often possible in pilot projects, achieving sustained organisational change is much more difficult.

The publishers could have been kinder to a European audience. The text would have benefited from shortening, and much of the data in the appendices could have been eliminated. A 100 page softback handbook would be just as helpful and cheaper.

One final observation. The title, *Curing Health Care* – an odd concept as doctors seldom cure anything and quality is about improvement, not answers – and the medical jargon in several chapter headings – for example, “symptoms,” “diagnostic journey,” and “remedies” – are presumably intended to target doctors by making them feel at ease, which is fine, if rather stilted. However, the authors then extend this thinking by arguing that the principles underpinning the project are based on “the scientific method.” This seems to imply two things: that doctors’ practice is really embedded in scientific method (not my experience) and that to change clinical practice the scientific hypothesis has to be shown to have been proved correct. My experience suggests that doctors are not such rational human beings! For example, despite Donabedian’s masterful work in the ’70s² and Maxwell’s³ and Berwick’s¹ seminal papers in the ’80s the ability of the medical profession to ignore and avoid addressing quality is striking.

But I am carping. The book is very readable; full of energy and excitement; and, if used astutely, could ferment much needed change in our hospital services.

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- 1 Berwick DM. Continuous improvement as an ideal in health care. *N Engl J Med* 1989;320: 53–6.
- 2 Donabedian A. *Exploration of quality assessment and monitoring*. Vols 1, 2, 3. Ann Arbor, Michigan: Health Administration Press, 1980.
- 3 Maxwell RJ. Quality assurance in health. *BMJ* 1984;288:1470–2.

MEETINGS REPORTS

Quality management and clinical audit. Study visit to the Netherlands, June – July 1992

Twenty delegates with clinical management backgrounds from across the United Kingdom participated in a three day visit to the Netherlands to study quality management and clinical audit processes. In particular, health care professionals in Britain need to be more aware of the developments in health in other countries, leading to the potential cross-fertilisation of ideas.

A national initiative led by Angela Schofield from the health services management unit at Manchester University, Charles Shaw from the clinical

audit unit of Bristol University, and Michael Deighan from Management Development Group of the National Health Service in Scotland, the visit was arranged and coordinated by Drs Paul Touw and Niek Klazinga of CBO (the national organisation for quality assurance in the Netherlands and collaborating centre for the World Health Organisation in quality assurance), widely regarded as an international leader in quality assurance.

The experience of CBO in quality stems from 1976 and continues to expand through a “consultancy” approach to clinical audit facilitated by doctors and other clinicians. CBO has also spear-headed international developments in consensus conferencing whereby national guidelines on a specific topic are developed by (medical) professional bodies and then transferred to local hospital level, becoming a principal topic for developing local standards and care planning.

The programme included visits to centres of excellence in quality assurance and clinical audit implementation with presentations by clinicians at the Academic Medical Centre, Amsterdam, and Stichting Deventer Ziekenhuizen, Deventer; presentations by CBO teams; opportunities to continue to debate specific topics in small workshops with experts; and time to examine and debate topics of common interest with experts.

Statistics and background theory presented on the first day allowed the delegates to widen their agendas and expectations for the subsequent visits to the hospitals. Both institutions dedicated an entire day with several senior clinicians and managers ensuring that delegates were entirely satisfied and fully informed. During the visits, the delegates examined management and medical structures; current operational and long term strategies; areas of concern where development was required; and, of course, whether all areas of the hospitals were meeting patients’ expectations. It is pertinent that the chief executives of both hospitals had previously been practising physicians – a somewhat unusual situation in the United Kingdom.

Subsequently, listening to presentations by the teams at CBO, the delegates had little doubt that what exists in the Netherlands is a centre of excellence which has been empowered to promote quality assurance activities nationally and support local implementation plans; the organisation has specific professional development programmes which attract key doctors and health care professionals from all over the country.

During the debates on the final day the delegates explored particularly the issues in promoting and developing quality management and quality assurance for the lawmakers (government, management executives, regions), purchasers and fundholding general practitioners, district medical units and trusts, professional bodies, academic institutions, and consumers. Two major statements emerged: quality management and the

move to clinical audit requires a strategic approach supported by the key stakeholders, as has been clearly demonstrated by the approach adopted in the Netherlands, and quality improvement is the responsibility of all health care professionals and requires continuous attention; continuous quality improvement needs to be emphasised, but quality should not become the preserve of one professional group. Managers in the Netherlands have a greater desire (and receive more encouragement) to join professional societies and thus to influence and share in decision making. The Dutch experts emphasised the need for rapid development of clinical audit and quality initiatives as multidisciplinary (agency) functions. One way to achieve this is by introducing a national body for quality assurance in health care to work with legislators and carers alike, whose focus is wider than that of practising professionals and can influence undergraduate and postgraduate thinking – a body operating as a think-tank, with the appropriate time, skills, and funding to amalgamate strategic managerial quality and clinical quality strategies. Such an organisation would need to guard against developing an elitist attitude as it became stronger.

The general consensus was that the visit had been invaluable; the delegates intended to continue to review their thinking regularly by forming learning networks. Nevertheless, modifying health care in Britain on the Dutch model may be difficult to achieve and require much wider explanation of the Dutch approach to be implemented successfully.

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Welsh Advisory Group on Nursing and Midwifery Audit (WAGNA) conference, Llandrindod Wells, October 1992

Two hundred delegates from Wales attended the first conference of WAGNA to launch the nursing and midwifery audit strategy and to announce the funding of audit development sites in Wales. In launching the strategy, Miss Marian Bull, chief nurse for Wales, gave it unequivocal support. Based on the view that education for audit and ownership of the audit process by nurses at clinical level are fundamental for audit to achieve improvement in clinical practice and patients’ experience, the strategy aims at encouraging freedom of approach by clinical nurses within a coordinated and supportive framework. The nursing and midwifery audit adviser and coordinator for Wales explained the strategy’s aim of involvement of practitioners and their ownership of the process – supporting local initiatives within a shared vision rather than imposing a central model.

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Curing Health Care. New Strategies for Quality Improvement

John Mitchell

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