Audit and standards in new general practice

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The future can never be predicted with absolute certainty. The unpredictable occurs with such outrageous regularity that most attempts at prophesy are futile. Nevertheless, during the next decade there are two things that can be predicted with almost complete confidence: there will be a lot more audit and a lot more standards. Audit and the related topics of standards, accreditation, and surveys of consumer opinion have irrevocably taken their places among the methods used to protect quality. Whether they will be effective depends on how they are used rather than their inherent properties. In response to the debate on the future of general practice initiated by the General Medical Services Committee the discussion that follows considers how audit can best be used to improve quality. Some comments may also be relevant to doctors in hospitals.

Does audit work?

Lembcke was one of the first to show that audit can work.[1] In 1956 he reported a scheme in which information was collected and compared with predetermined criteria and the findings reported to participating surgeons. In one American hospital he was able to show an improvement in the proportion of major pelvic operations in women that could be justified. Before audit only about 30% of operations were justifiable, but after audit this increased to an average of 80%. Since then many enthusiasts of audit have sought to emulate his example. Success has been elusive. Brook and Williams reported the success of a quality assurance programme set up in 1971 as an experimental prototype for audit in America.[2] The administration of injected drugs to outpatients was compared with criteria for administration established by doctors. Payment for injections was denied if the medical criteria were not complied with, and the number of injections given fell by more than 60% over the two years of the study. This confirmed the central methods of audit and they have been followed ever since. Despite this, evidence for the success of audit in America is hard to find. For example, a study of a random sample of American hospitals in 1990 found that quality assurance programmes were still a source of frustration and that respondents had some doubts about the benefits.[3]

Audit in Britain

Audit has a shorter history in Britain. We have imported from America the methods of criteria, feedback of performance, and comparison with peers to improve clinical practice. This strategy has sometimes been successful, but on most occasions sustained improvements have been unusual. In a review of feedback as a means of changing clinical behaviour in hospital doctors Mitchell and Fowkes found that change was not guaranteed.[4] They classified the types of feedback into passive and active and concluded that simple feedback was relatively ineffective but feedback combined with some additional intervention was more likely to lead to change.

In hospital medicine, with its hierarchy of senior and junior doctors, the prospect of the traditional form of audit promoting change may be better than in general practice, where the egalitarian structure makes it more difficult to reach agreement about criteria and standards. Many published audits of general practice have failed to complete the audit cycle: the introduction of change and subsequent re-evaluation have been omitted in favour of collections of good intentions. In their review Hughes and Humphrey report that attempts to tackle problems and change practice were more difficult to find than descriptions of current performance.[5]

The outlook is not uniformly gloomy. There is evidence that general practitioners welcome the provision of information about their performance[6] and that they are willing to share information about their work.[7] In a study of the recording of preventive measures in 29 practices review of the records and group discussions about the findings produced an increase in recording two years later.[8] Similar success was reported by Maitland *et al*,[9] although neither study was able to include a control group. In an audit of care of diabetic and hypertensive patients practitioners encountered difficulties in setting criteria, and although the audit improved recording, it had no effect on outcome for the patients.[10] In another study a sequence of standard setting and feedback of performance led to improvements in prescribing,[11] but these were not maintained once the intervention was withdrawn.[12]

Some lessons emerge from this experience. Audit conducted in the traditional manner requires skilful, prolonged, and intensive effort. The feedback must be combined with active intervention to encourage change. If carried to extremes this degree of supervision of general practitioners will have unfortunate consequences. It suggests to practitioners that they cannot be trusted with quality and that they have only a limited role in its assurance. Responsibility for the quality of the service will have been transferred to the organisers of the audit and their managers. This approach must lead to disillusioned professionals, exasperated managers, and audit rendered ineffective through lack of cooperation.

Audit and practice management

A clue as to how this scenario can be avoided is found in reports from general practitioners who have shown that they have improved the care provided by their practices.[13-15] Sometimes this is not even described as audit; it is just getting on with the job and sorting out problems.[16,17] These practitioners took responsibility for the quality of their practices and used audit as part of practice management with the motive of improving care rather than doing audit for its own sake. The fundamental importance of teamwork and practice management to good quality practice has been accepted for some years.[18] Would audit be more effective if it was used in this context?

The difficulties encountered in America have led to a new approach to audit known as continuous improvement or total quality management.[19] This is a style of management that returns the responsibility for quality to the people doing the work.[20,21] The method has been used in Japan and is now being taken up by more

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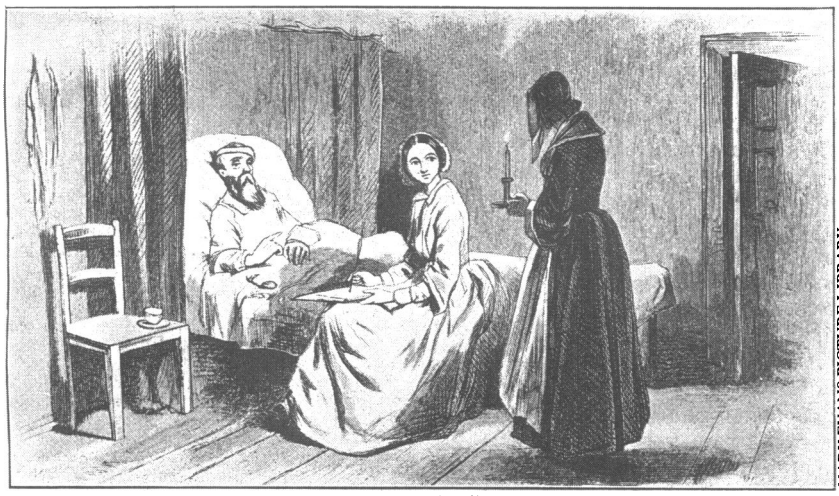

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Florence Nightingale was the first serious practitioner of audit

enlightened organisations in America and Europe. It is not an alternative to audit but a framework in which audit and its methods such as criteria, feedback, and comparison can be used. Evidence from industry suggests that it may enable audit to flourish. There are three main elements: firstly, knowledge of what the patient requires and feels; secondly, a people centred style of management; and, finally, continuous innovation to raise the level of quality.[22] General practitioners are developing new skills in management encouraged by the new service management courses, the contract, and the demands of fundholding. They are potentially the managers of their own teams, and a practice team that cooperates effectively has many of the features of quality circles that are one ingredient of total quality management. Including the whole team may help to overcome some of the natural anxieties about audit experienced by general practitioners. Nurses and other staff may be less suspicious about improvement of quality. It should be acknowledged that the first serious practitioner of audit was Florence Nightingale.[23]

Irvine has shown that audit can be absorbed into practice management.[24,25] The practice audit plan is another example that includes the practice team.[26] Although there is no documented evidence of the value of total quality management in general practice, both the limited success of traditional audit and the effectiveness of the new approach in industry suggest that audit should be incorporated into practice management in this way. Research on how this style of audit can be introduced and the consequences for the outcome of patients is essential. Practices that are in control of audit rather than controlled by it will be better able to respond to other initiatives such as national standard setting or accreditation schemes. Traditional audit is more likely to create antagonism and resistance to new ideas on quality. The medical audit advisory groups should educate practitioners in the methods of total quality management rather than instigate audit schemes themselves. Unless this is done there is a risk that they will take control of audit and responsibility for quality out of the hands of practitioners

Introducing standards

Although more standards will be set in general practice in the next decade, the way this will be done and the impact on patient outcomes is even more unclear than it is for audit. The science of standard setting has been extensively investigated in recent years. For example, there have been reports on the most appropriate way to achieve consensus,[27] and the development of methods for using implicit standards.[28] Guidelines that have the authority of expert groups are already emerging in Britain.[29] Applying standards appropriate to populations of hospital patients to patients in general practice has dangers,[30,31] but provided that the characteristics of the patient population are taken into account a growing number of acceptable standards will become available. However, standards are worthless unless they lead to improved quality. How can standards be used most effectively?

There are three main considerations: firstly, who are the standards intended for; secondly, the level at which they are set; and, thirdly, how much elasticity should be allowed. Standards can be set locally, either within the practice or between a small number of practices. They can also be set more widely—for example, for a region or for the entire nation. The stringency of standards can also vary. They can be set at the minimum acceptable level, at the maximum possible, or somewhere in between. Once the stringency of the standards has been agreed, how much elasticity is to be allowed? Is compliance with the standards mandatory on all occasions, or should there be some flexibility to take into account the wishes and circumstances of different patients? The progress towards standards is inexorable, but if quality is to benefit answers to these questions are urgently required. The first to tackle is: should standards be set locally so they will have the support of local general practitioners and take local circumstances into account or should they be set over a wider area, perhaps even nationally, and thereby ensure that local concerns do not lead to the adoption of less than acceptable stringency?

Acceptance among general practitioners

Evidence from The Netherlands shows that setting standards locally can play an important part in the success of audit.[32] More information is needed about the introduction of standards at a local level in Britain, although a study of standard setting in the Northern region may answer many of the questions.[33] The difficulty of setting national standards has been shown by the introduction of targets for cervical cytology screening and childhood immunisation in Britain. For some practices the level of the standards has been unrealistic and they see no point in even trying to reach the minimum level. Others have found that the attitude of one patient can lead to a substantial loss in personal income. It is too early to decide if targets will be successful in terms of increased compliance and reduced morbidity and mortality. If they do succeed the pressure for more national standards in some form will increase.

The Netherlands already has a national programme of standard setting for general practice.[34] These standards are seen as guidelines rather than absolute instructions and there seems to be broad support for them among Dutch general practitioners. The acceptance of the guidelines owes much to the supportive role taken by the Dutch government. After the upheaval of the past few years general practitioners in this country will not be as receptive to the idea of national guidelines, but there will be guidelines all the same. The college and the General Medical Services Committee would be wise to consider jointly how guidelines for general practice can be devised by the profession and in a form that general practitioners can use in practice based audit. If medical audit by the method of continuous improvement can be introduced into practices in the next few years then general practitioners will be more willing to respond to the challenge of national guidelines. If audit follows the traditional pattern acrimonious battles about standards can be safely predicted.

The role of patients

It was hoped that patient participation would lead to improved communication and an equal relationship between doctor and patient.[35] This has not yet happened because only a few practices have a patient participation group and even in these only a small proportion of the practice list takes part. Although patients should take part in the assessment of quality, participation groups are not likely to be the most common method for the foreseeable future. There may be a role for the Patients' Association and similar agencies in preparing national guidelines or accreditation schemes, but patient representatives are unlikely to be included in medical audit advisory groups until general practitioners have complete confidence in the process of audit. Participation and representation are not yet options.

The role for patients chosen in the new contract lies in the survey. Family health services authorities have been encouraged to undertake surveys of patients' opinions and the audit advisory groups may be asked to respond to the findings. Already some family health services authorities have conducted surveys, although the quality of many of these is doubtful. It is not clear how the authorities plan to act on the findings so it is perhaps just as well that the surveys have so far been relatively meaningless. Nevertheless, there are reputable methods,[36,37] and surveys and response to their findings will rapidly become more sophisticated. Patient satisfaction is an important outcome of care and must be included in any practice assessment, but if audit is to become truly patient centred it must go beyond surveys of opinion and include patients in the identification of problems and the setting of standards.

The increasing attention that will be given to the views of patients is potentially the most important consequence of the changes in the NHS. One definition of quality used in total quality management is "meeting customer requirements."[21] Although most doctors would think that quality is more complicated than that, all will accept that the practice of medicine is built on an understanding of the wants and concerns of individual patients. The "Personal View" section of the *BMJ* has repeatedly been a poignant record of the difficulties doctors have in communicating and working with patients. The art of doctoring needs as much attention as inputs, outputs, targets, or contracts. If we do not know the opinion of patients we will be less effective doctors. There is growing evidence that what patients think of the care they are given is related to their recovery from illness.[38,39] It also contributes to compliance[40] and whether they use the service again.[41]

It has become customary to describe the activities of the health services as health care. This devalues the word care. Care is not just an activity, it is an emotion—we care about whether our patients recover as well as care for them. As far as audit is concerned, our aim should be effective methods placed within a management framework of continuous improvement that is propelled by a preoccupation with the patient's experience of illness. This kind of audit has potential to improve care in both senses of the word and to revitalise our relationship with patients. To borrow the words of Donabedian,[42] "This being the case, we have no choice but to proceed."

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