practising physicians of the quality and efficiency of a service ordered by other practising physicians." Unfortunately, any evaluation is threatening—and peer group review is more threatening than self-evaluation. In our imperfect world self-evaluation⁴ of any degree and of any value is improbable, and therefore evaluation by audit and by peer group is more likely to achieve its objectives.

Medical Records as "Crunch Point"

Apart from any arguments that by themselves accurate records do not reflect quality of medical care, it is true that accurate and if possible standardized records are absolutely essential for any type of peer group evaluation. At present there would be considerable difficulties with records, both in hospital and in general practice, to the extent that audit might falter at first base. This then is likely to be the crunch point in mounting a system of medical audit. Somehow, someone must persuade hospital doctors, and general practitioners that good record keeping is absolutely essential. In general practice the present design of the record card is a deterrent in itself. Even supposing the use of a new A4 size record card, the method in which the material is recorded would have to be altered from the present individual, haphazard system. Standardization and structuring of the type of material recorded would be essential in any system of audit. Systems using problem-oriented recording might have a part to play. Thus the preparations are daunting indeed. After many years of debate, our present record card is scheduled to be replaced by the A4 folder but it is difficult to see that process being completed in the next five years. How much longer would it take to introduce and make operational a standard type of record in which information relating to the "why," the "how," the "what," and the "when" is easily retrievable?

The application of medical audit depends on evaluation by a peer group using criteria that have previously been agreed. Whatever they are, the agreed criteria depend not only on an adequate record system, but also on standardization of definition and classification. Sanazaro states, "of course, in primary medical care relatively few diagnoses or conditions lend themselves to rigorous auditing by essential criteria—but these few account for a surprising proportion of patients seen." I disagree with the latter part of this statement. There would appear to be comparatively few conditions that would lend themselves to accurate audit and they would comprise only a small percentage of the practitioner's work. Even those conditions that lend themselves to audit—the so-called simple physical problems, such as an acute appendicitis—should have a related area where the attitudes and interpersonal relationships between doctor and patient are important and worthy of evaluation. When one considers applying standard criteria to the majority of consultations in general practice, one sees immediately the difficulties of agreeing criteria, definitions, and classifications.

The difficulties inherent in medical audit seem legion, but the objective is to evaluate the quality of medical care, to maintain the standards of excellence, and if possible to improve those standards that fall below the accepted levels. Surely in this country it is time we considered quality as well as quantity, and faced the difficult task of organizing pilot studies of medical audit both in hospital and in general practice?

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Necessary, but Rigidity Greatest Danger

A. K. THOULD

Though obviously concerned with medical practice in the United States, Dr. Sanazaro's paper nevertheless contains some clear lessons for British doctors. The concept of the medical audit is not new, and must be familiar to most of us—at least in its broad outlines. The points at issue are is it right for this country, do its advantages outweigh its disadvantages, and, above all, will it be acceptable and can it be made to work?

We are all in for a major organizational upheaval in April 1974 with the reorganization of the Health Service. Doctors are being encouraged to take a full—indeed fuller—part in administration of the Service, and their advice on running it, and apportioning resources, is clearly going to be vital. Let us hope it will be heeded. The new advisory committee structure is going to be cumbersome, and, unlike the turtle, the voice of the individual doctor is going to be less clearly heard in the land. All the more important, therefore, that doctors should get together, decide on the needs of their medical practice, and make sure that these needs are noted and acted on. Unless they speak clearly and with authority, however, the necessary facilities are unlikely to be made available.

There always seem to be financial reasons for delay in an overorganized Service.

This is where the principle of the medical audit can be put to good use. Properly used, it can enable doctors to review the efficiency of their methods, identify where extra resources are needed, or under-used resources wasted, and make appropriate recommendations with the force of accurate and usable statistical information to reinforce their advice. As I see it, in Britain the Cogwheel organization is the basis for making use of the medical unit. On the whole, hospital divisions are not large, individuals in it know each other well, and discussion can take place in a relaxed and informed way given the will to make audit work. The major disadvantage, however, is that some doctors may see audit as a means by which their individual practice can be criticized and their freedom threatened by their colleagues (peer review).

Cautious Approach Needed

If the medical audit were to be introduced with these fears paramount, it would be a disaster and would kill it. I would advocate, therefore, that a more cautious approach would be wiser. Where the Cogwheel system is working well, could not pilot schemes be set up and reported on frankly in the medi-

cal press after a year or two's experience? If it can then be seen to work, then others would see the need to adopt it themselves.

Sooner or later the nettle must be grasped. Implicit in any practical medical audit is the need for an individual's performance to be measured against those of his fellows and against nationally accepted criteria of good practice. If we look at this honestly, can we seriously argue that this should not be so? What needs to go hand in hand with this is the assurance that comparison does not equal persecution. None of us practises perfect medicine, and if we are adult men and women surely we are prepared to alter our own methods if we can be shown that other methods are better? If something along these lines is adopted, then the American requirement for recertification of doctors at intervals becomes irrelevant. Recent experience of the furore over the General Medical Council does not lead me to expect that recertification has any hope of acceptance in Britain. Nor, I submit, is there any necessity for it, provided doctors make it obvious that they are making the necessary moves to keep their standards high.

It is here that the postgraduate clinical tutor has such an important part to play. By organizing local seminars, tutorials, and lectures his colleagues can be kept up to date with modern thought, and these ideas can be readily disseminated, particularly when the medical audit ensures that ignorance would not be respected by one's colleagues. Nevertheless, I see a great danger in rigidity of practice becoming apparent. If we all have to conform to a norm, then enlightened and ethical experimentation and variation of methods *might* be seriously suppressed. This would be highly undesirable, and any individual doctor must have the right to vary his methods from those of his colleagues, provided his results are not disastrous. We do not want potential Gallileos discouraged. I see this possible rigidity as the greatest danger of the medical audit.

Can the audit system be applied to general practice? It would seem that where group practices exist—and the tendency is for them to become the normal method of practice now—then some form of medical audit is again practicable. The problem seems to be, however, of how good general practice can be defined. Again, locally this seems to be a matter of education via the postgraduate tutor, and nationally perhaps the concern of the Royal College of General Practitioners.

Irrelevance of Professional Audit

In North America professional audit organizations exist. These have no relevance here. In the U.S.A. tissue committees are widespread, to protect the patient against unnecessary operations. A close look at the amount and type of work in our own hospitals would not suggest that these committees have any useful function here: our problems arise more from getting necessary operations done in the face of inadequate resources.

A vital necessity in any medical audit scheme allied to the Cogwheel system is the provision of proper information. National norms of, for instance, geriatric bed provision are of limited usefulness since local conditions vary so widely. Conversely, the knowledge of these variations is essential; so is information such as average lengths of stay for various conditions, mortality rates, incidence of complications, and speed of return to work of the individual. Some form of follow-up into the community needs to be worked out and then presented to doctors so that they can organize themselves and their resources to give the most efficient service.

Problems of national importance could perhaps be studied by organizations such as the Nuffield Foundation. There seems to be a place for each regional health authority to have an organizational research team, provided trained individuals of sufficiently high calibre can be found. These could investigate regional health problems in depth and submit their findings. An example might be local health provision for patients with rheumatological disorders and its impact on their usefulness in the community. Against what would appear to be the best obvious practice, doctors could then compare their own performance and make suitable recommendations. Cost control as well as desirability of method also need to be looked at by doctors as groups with common interests, so that resources can be most efficiently used.

In summary, therefore, the medical audit need not be feared as a means by which the individual doctor's right to practise as he sees fit will be further curtailed. Rather, it can better be looked at as a weapon in the hands of doctors to make the Health Service more efficient, to raise standards, and perhaps increase resources. At the very least, available resources can be better used. The greatest danger, it seems to me, is that medical practice may become too ossified, and that the individual with original ideas (perhaps regarded as bizarre by his colleagues) may be needlessly discouraged. We do not want to re-invent another medieval church.

The Profession's Own Responsibility—a Swedish View

LARS WERKÖ

To date medical audit has been discussed comparatively little in Sweden, mainly owing to two features of our medical care: firstly, because much of this is based on the hospital; and, secondly, because most hospital divisions have been composed of small closely knit teams which have allowed free interchange of ideas and personal supervision of junior doctors. Nevertheless, this situation is likely to change soon and may make the introduction of medical audit imperative. If so, I believe that any system should be run by the medical profession itself.

The Swedish Health Service, and in particular our hospital services, is under the close surveillance of the Board of Health

and Welfare (B.H.W.), which itself comes under the Government's Department of Social Affairs. But the local counties are responsible for running, equipping, and staffing almost all the hospitals and these have the right to levy local rates for this purpose. Typically, in Swedish hospitals the medical staff is employed full time specifically to treat inpatients as well as those seen in the outpatient departments. Thus physicians or surgeons working outside a hospital have no right to interfere with its services and the hospital staff is solely responsible for the conduct of medical care—to the patient and to the B.H.W. for the medical standards, and to the county for the financial aspects.

In most Swedish hospitals the medical staff is usually small, though the junior doctors working there as part of their specialty training (similarly to house physicians or registrars) have usually stayed on much longer than the required four or five