years, partly at least because their pay was so good. So far this situation has meant that our younger doctors have not moved out of hospital practice into general practice or office specialties. This state of affairs has been tolerated, firstly, because any relative shortage of hospital doctors would have precluded the rapid development of our hospitals and, secondly, because the output of medical graduates has been so small that there has been no pressure from the newly graduated to enter hospital training.

The Hospital Team

This special pattern in Sweden is relevant to any discussion of medical audit because it has meant that an ordinary hospital division (in medicine or surgery) usually consists of a small team: a senior physician, acting as head of the division; a senior physician acting as assistant chief; and four to eight younger doctors, many of whom have had four to six years' experience within the specialty. This small group has worked closely together with a daily exchange of views, and the two senior doctors have kept a fairly regular check on their younger colleagues, usually by a daily review of the medical records. But there are other opportunities for this type of thorough personal supervision, including the regular, daily session in the x-ray department, and meetings with colleagues in other specialties at staff conferences or grand rounds.

All this has meant that there is a complete absence of any type of formal medical audit. Our B.H.W. has a statutory obligation to visit the hospitals and check on the work conducted there, to be done "in conformance with scientific knowledge and generally accepted medical experience." Nevertheless, the B.H.W. rarely makes use of this power, undertaking a formal inspection

only when something has arisen that compels it to act, since it is particularly concerned not to interfere with the role of the counties. For this reason the B.H.W. may seem normally to be only superficially interested in the actual quality of medical care in our hospitals.

Imminent Changes

All this pattern of organization is rapidly changing. Recently the output of our medical schools has increased considerably and the necessity for the newly graduated doctor to get a job as a house physician for his specialty training has meant that there are now demands that all those so-called junior doctors who have completed their formal training should leave hospital and start work on their own. The flow of young people through the hospital services will thus increase considerably, putting much more responsibility on to their seniors to teach them and check their standard of medical care. When this situation has become more prevalent then organized medical audit will have to be introduced in some form. I hope that it will be introduced through the professional organizations as a form of peer review rather than through formal inspection from the B.H.W., even if both possibilities were available. But if the B.H.W. is to delegate any responsibility for controlling quality it will mean that our professional organizations will have to be capable of conducting a thorough peer review. The question of recertification is unlikely to arise as part of any peer review system. Though this has been discussed only rather superficially so far, there seems no general desire here to introduce such a difficult and administratively awkward way of controlling the standards of medical care.

Australian Progress on Recertification

JUNE HOWQUA

Doctors in Australia are under close scrutiny at the moment, receiving an unfavourable press, for the Australian Medical Association and various other societies are resisting the implementation of the present Labour Government's National Health Plan—even though our Opposition party is also committed to plans for improving the health services. So change is inevitable, and the present mood of the public makes it a particularly opportune time for doctors to show that they want to raise their individual and collective standard; that they recognize that medical care is usually less than optimal; and that they accept self-criticism and peer review, such as medical audit described by Dr. Sanazaro.

Lip service has been paid to medical audit for some years, but nowhere in Australia is it practised adequately and only a few hospitals have some units carrying out an intermittent, self-imposed audit. Of the various postgraduate medical colleges, the one interested in audit is the Royal Australian College of General Practitioners, which considers practice audit both feasible and desirable and its members are likely to take part in it voluntarily fairly soon. Other colleges consider that their role is purely educational.

The impersonal nature of at least the first steps of medical audit, as described by Dr. Sanazaro, and also the adoption of essential criteria rather than optimal criteria, would be more acceptable in Australia than straight peer review, for discussions about "peers" tend to become heated and acrimonious, and certainly experienced clinicians can successfully take "short cuts" which would leave their recorded management of a case less than "optimal" but extremely successful as to patient outcome. My inquiries around Australia have indicated that appreciation and acceptance of the total value of medical audit are unanimous by medical administrators, and are agreed to as an ideal for an undefined future by clinicians, who exhibit anxiety when the means of implementation are discussed.

As Dr. Sanazaro states, adequate medical records are basic to clinical assessment and the problem-oriented history is coherent and simple for extracting data. Experience in many different centres here has shown that this method of recording is much more difficult to introduce than expected because of entrenched attitudes of the staff, even those recently graduated. Full-time staff are more likely to carry it out than visiting staff, and junior consultants who have had experience of this method in the U.S.A. have the best results. Of the Australian teaching hospitals, one has successfully changed to the problem-oriented method, some consider they have had limited success, and others frankly admit failure. Nevertheless, all agree that it is desirable, and undoubtedly it will be adopted throughout the country in a few years' time.

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Relicence and Recertification

Relicence and recertification have been discussed only recently in Australia; even state recognition of a "specialist," for which application is voluntary and not mandatory for practice as such, started only in 1971. The various educational bodies have been examining the situation, which is considered to be very "touchy." Even so, all agree on the necessity for continuing education. The Royal Australian College of General Practitioners has an active educational programme consisting of self-check papers sent out each month, and such papers periodically returned to an examiner could provide a continuous assessment of the doctor's performance and be the basis for recertification. The Royal College of Obstetricians and Gynaecologists Australian Council has instituted a new title, Fellowship in Australia in Gynaecology and Obstetrics, which signifies that the holder, already a member or Fellow of the Royal College of Obstetricians and Gynaecologists, is in good standing and is a fully trained and competent specialist obstetrician and gynaecologist. The regulations include a clause which requires the continuing education of the holder and he will have to re-apply for the qualification ten years after he has obtained it, in the first instance, and thereafter every five years. The council states that this further diploma is needed because of the ever-advancing growth of knowledge and technology in the practice of obstetrics and gynaecology. To obtain the initial Fellowship two years' training additional to the minimal requirements of Membership of the Royal College of Obstetricians and Gynaecologists is required.

Mandatory Refresher Courses

The Royal Australasian College of Physicians considers that ideally some form of continuing physician assessment is necessary, but, again, the college's role is purely educational, and not concerned with possible recertification, which would be a state matter. Nevertheless, the college's efforts to maintain and improve the standards of its members could be

important if recertification is established, for it believes that re-examination might thus be avoided.

Last year the college's education committee recommended that there should be a mandatory attendance at a continuing education course every year, with active rather than passive participation. Many Fellows, however, disagreed that attendance should be mandatory, argued that it would be impossible to enforce it within the college, and suggested that it would be better to organize such an excellent programme that the individual feels that he would have to participate. In actual fact the first course, which I attended, was held last year and was a great success, and all who attended said that they would support further courses. This one was designated "Recent Perspectives in Medicine," emphasized and elucidated pathophysiology, and consisted of sessions in eight different disciplines of internal medicine. It was attended by a wide spectrum of physicians—older clinicians, young clinicians, research workers, and academics—and the lecturers were mostly full-time university or hospital clinical research workers in the 35-45 age group.

The first course preceded a college meeting, and next October most of its meeting will be taken up by an educational programme. Most people think that such courses must concentrate on clinical data of all kinds, avoiding too much theoretical or research material; hence speakers need to be carefully chosen and briefed. I found the course interesting, enjoyable, varied, and never boring nor condescending—an important aspect for the older clinician. The Royal Australasian College of Surgeons has recently formed an education committee to examine the problems and formulate a programme for its members.

Thus in Australia the need for continuing education is recognized and plans are proceeding; the requirements for specialist and consultant status are becoming much more stringent; and orderly and logical record keeping is being attempted. But medical audit and peer review are understood and accepted by relatively few, and there is virtually no machinery for it to be carried out, either technical or financial.