PRACTICE OBSERVED

Audit at Work

The future

ROBIN C FRASER

Doctors are still confused about, and suspicious of, medical audit. This was apparent not only at the meetings in Lincolnshire but also at the recent major conferences on medical audit organised by the General Medical Services Committee (GMS), the Royal College of General Practitioners (RCGP), and the Royal College of Physicians. I wish to give my own views on the concept of audit and on what is required to make audit work.

It must be stated at the outset that audit is doomed to failure if attempts are made to impose it. Participation must be entirely voluntary, without any element of compulsion or imposition of external sanctions. Criteria of satisfactory standards must be determined and agreed on by the participating doctors and not by some external authoritarian source. This does not mean that many doctors will not be prepared to consider suggestions or seek advice and support from outside their practices.

Structured approach to audit

What is meant by medical audit? In simple terms it is the act of looking critically at one's own professional activities with the ultimate aim of improving patient care. There is nothing particularly new about this—many doctors have been doing this for years without calling it audit. What is new, however, is the growing realisation that the gathering of objective evidence of performance must be a central feature. This requires a structured approach using a method that creates confidence in the quality of the information generated. An approach along the following lines is suggested:

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- (1) An area of inquiry, interest, or concern must be identified. This would be the proper role in audit of case discussions, practice meetings, etc.
- (2) The specific aims of the audit must be set out.
- (3) Criteria of acceptable standards of performance must be identified and agreed on by all participants.
- (4) An appropriate and reliable method of collecting data must be devised.
- (5) A period for data collection is required.
- (6) The data must be analysed and compared with the criteria of acceptable performance previously agreed on to identify any changes that may be required.
- (7) A further data collection period is required to identify and measure these changes to evaluate their effectiveness.

Audit and the general practitioner

Interested general practitioners could participate in medical audit in various ways:

- (1) A doctor or a partnership may wish to identify a particular practice problem and collect some relatively simple numerical information that requires little special organisation, the results of which would be for the use of and relevant to the practice only.
- (2) Some doctors may wish to undertake a more sophisticated analysis within their practice, seeking help and advice from outside the practice, particularly with regard to design and analysis.
- (3) Some may wish to collaborate with colleagues in neighbouring practices so that group discussions may be held to compare findings.
- (4) Other doctors may not wish to participate in the design or analysis but would be prepared to collect data for larger studies organised from outside the practice. The information generated would then be fed back to the voluntarily participating doctors for their own use.

Financial support

Much more may need to be done. In my view the essential feature of "the new audit" is collecting and evaluating objective evidence of performance, which replaces reliance on unsubstantiated opinions and impressions. It is vital then that general practitioners have ready access to advice on methods of audit and to a facility for data processing and analysis. Some special funding would be required for the personnel and equipment needed to deliver this service.

The extent of the financial support would be determined by the number of general practitioners who will actually initiate or participate in audit activities. Whether it is while waiting for the Department of Health and Social Security (DHSS) to provide this support will depend on the degree to which the lessons from audit activities result in more efficient use of limited resources—that is, improved cost effectiveness. (Some modest evidence has been presented from Lincolnshire—for example, a saving of 200-400 injections of vitamin B₁₂ in two small practices in a year.)

No one knows how many doctors will participate in audit, the level of expertise at which they will operate, or the exact contribution to cost effectiveness that audit will make. It would be sound, common, and economic sense for the DHSS to seek to answer these important questions. It could be done by setting up one or two audit advisory centres on an experimental basis to assess their results. Encouraging general practitioners to undertake audit without providing the support they need to do it is an exercise programmed for failure. Give us the tools and we will finish the job.

This is the second of two articles.

Sex Problems in Practice

Principles of managing sexual problems

ELIZABETH STANLEY

When the most common causes of sexual problems are understood the broad treatment strategies underlying their management become self-evident and may be seen as little more than common sense. Though there is much overlap between them, these strategies may conveniently be considered under the headings of education, "permission giving," teaching communication skills, redefining "success," and removing "performance pressures"; their application is shown in the diagram.

I will describe several specific tools for treatment that relate to these general measures. As with all kinds of tools, however, it is the way that they are used rather than the actual quality of the tools that determines their effectiveness. Not all doctors may feel that they have the aptitude or desire to use them. Managing sexual problems effectively requires a certain degree of sensitivity and intuition not given to all, just as not every doctor is

born with the intrinsic qualities needed to become, for example, a cardiac surgeon. Perhaps the best guide we have to prevent us falling off the "tightrope" (mentioned in the first article in this series) is our own feelings. Sex can be a highly emotive subject, as much for doctors as for patients. If our feelings about it are predominantly ones of discomfort, it would seem preferable not to take on the management of sexual problems. Fortunately, the resources throughout the country to which we can refer such patients are increasing. A list may be obtained from the Association of Sexual and Marital Therapists, PO Box 62, Sheffield S10 3TS. Training for general practitioners in how to manage sexual problems is now becoming more widely available. Information on analytically based training exclusively for medical practitioners can be obtained from the Director of Training, Institute of Psychosexual Medicine, 111 Harley Street, London W1, and on multidisciplinary training in incorporating behavioural techniques from the Association of Sexual and Marital Therapists. Whether or not we choose to deal with our patients' sexual problems, understanding the principles of their management may make letting our patients talk about their sexual problems feel somewhat less like opening "Pandora's box."

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Education

Education can be the simplest but most potent treatment as long as one important rule is observed. Understand first what your patient does not understand—and only then educate. Nearly every patient with a sexual problem feels that he or she is unique and that no one else has similar difficulties or abnormalities. Moreover, many of their fears and fantasies may be quite irrational, but until they are verbalised little can be done to dispel them. Giving our patients "permission" to have such irrational feelings may facilitate history taking and lay a good foundation for using educational procedures.

Two specific treatment tools can be used to help overcome the problems of ignorance of the female genital anatomy. These I call the "fantasy trip" and the "guided tour."

FANTASY TRIP

One of our more difficult tasks may be helping the woman recognise and articulate those irrational fears and fantasies about her genital area which can be so inhibiting to her sexual responsiveness. We may be helped in this by taking her on a fantasy trip into and out of her vagina.

The woman is asked to imagine that she is less than a millimetre tall and is going to walk into her own vagina. She is asked to describe what she can see, touch, and smell, and how she feels about being there. These questions are then repeated as she walks into her vagina, through the cervix, and even into her fallopian tubes. The level of ignorance that this may reveal is sometimes quite astonishing. She is then asked to walk out again, all the time describing her feelings about this experience. These are usually very negative to begin with, but once her true anatomy is explained to her, preferably through self-examination combined with the use of three-dimensional models (available from Jim Jackson & Co, 33 Rickdale Avenue, Cambridge, Massachusetts 02140 USA) or failing that, good pictures.¹ Fascination usually begins to take over and her feelings gradually become more positive.

One patient with vaginismus became quite agitated beginning the return journey, and it was only then that she suddenly recalled the fearful pain of having a vaginal pack removed after a hymenectomy performed some years before. It then emerged

that her chief fear about intercourse was not the penis entering her vagina, but getting stuck and causing damage once it was inside. That marriage was consummated shortly after this particular session.

GUIDED TOUR

For the "guided tour" the woman is asked to get up on the examining couch in a half-sitting position with her legs spread apart, supported partly by the backrest and partly by her elbows. Preferably her partner is also present. A mirror is then placed between her legs and adjusted so that she can see her vulva clearly. She is then asked to locate her inner and outer labia, the entrance to her vagina, her clitoris, urethra, and anus. Her partner is then asked to do the same. A vaginal speculum can then be introduced (a transparent one with its own light is best for this purpose), and with careful adjustment the woman can view her own cervix as well as the walls of her vagina. This provides an opportunity for discussion about the normal vaginal secretions which so many women feel are abnormal and "dirty." Throughout this procedure both partners are encouraged to express any feelings they may have about what they are seeing and what is happening. Quite often these are more negative than positive, but it seems that for many people simply putting these feelings into words is in itself remarkably therapeutic and may be the first step towards developing a more positive and healthy attitude towards their genitalia.

When the woman and her partner have both described as much as they can about the woman's anatomy, the doctor can then begin to educate, using simple, everyday terminology. Ignorance about the structure and function of the clitoris is almost universal in patients with sexual problems, regardless of the level of education or intelligence. A straightforward lesson on the anatomy of the clitoris and the physiology of sexual arousal and orgasm can go a long way towards resolving many sexual problems. Again, three-dimensional models or good pictures may be of great help. Most patients say that this experience, no matter how embarrassing it may have seemed to begin with, was one of the most valuable aspects of their treatment. In addition to its educational value, there is a large component of "permission giving" in this procedure, and there is little doubt that it facilitates more open and frank communication about sexual matters between the couple when both have been present.

There is some debate about whether male doctors can use such procedures, and if they do whether they can be as effective as female doctors. Although I am in little doubt that it is easier for the woman doctor, it has been my experience that as long as he is comfortable in what he is doing the male doctor can be every bit as effective as a female doctor. For men, however, a chaperone is obviously advisable, especially if the patient's partner is not present.

Vaginal self-exploration can be a valuable additional experience for the woman. This may be done in the privacy of her home, but when done in the surgery a useful discussion of her feelings about this experience can take place, and the "permission giving" component of this exploration may be greater.

"Permission giving"

"Permission giving" may seem a somewhat abstract concept of treatment, but it is the easiest and most effective way to help our patients overcome inhibiting cultural taboos. In effect we are "giving permission" throughout every minute of the consultation, simply by virtue of the fact that we are listening and talking about sexual matters in a frank and open way, with no more embarrassment or discomfort than we would feel about any other medical topic. For doctors who may wish to develop greater comfort in talking about sexual matters in a professional

setting there are seminars designed to meet this need.² However, all the specific tools for treatment described contain a strong element of "permission giving."

Teaching communication skills

If we can simply tell our patients that contrary to popular myth they do need to tell each other what they like and dislike during lovemaking, we will have a long way towards helping many couples resolve their sexual problems. It may also be helpful to explain their responses to any given physical stimulus can vary enormously according to their mood and many other factors. What may feel good for one minute may not still feel good two minutes later, just as something that feels pleasurable on one occasion may not necessarily feel so on another but may be enjoyable again at some future time. We need to stress that the only sure way of communicating these varying responses to one's partner is through words. Although non-verbal communication can also be used, this is more likely to be misinterpreted.

The other aspect of communication that needs to be dealt with in most couples with sexual problems is that of sharing emotional feelings. Breakdowns in this kind of communication frequently occurs as a result of "double" or "mixed" messages, when the words used do not accurately reflect the feeling experienced. A common example is the response to the question "What is the matter?" "Nothing is the matter"—but expressed in an angry or belligerent tone of voice. Clearly there is something the matter, but such a response leaves the receiver of the message confused, and negates any possibility of resolving the matter further. When the tone of voice and body language do not appear to be consistent with the statement made, there is a good chance that a double message is being sent. If this happens repeatedly over a long time, no matter how trivial in itself each incident may seem the frustration and resentment that accumulates can diminish sexual responsiveness.

There is a simple technique that can be taught to any couple when both partners are reasonably well in touch with their emotional feelings that prevents double messages occurring and facilitates a healthy resolution of the conflict. This is based on the Gestalt concept of "I" language³ and consists of four basic steps.

The first step is to recognise and articulate the actual emotional feeling experienced rather than any intellectual thoughts about or consequences of that feeling. The second step

is to ensure that feelings are expressed using the first rather than third-person singular. It can feel quite different being on the receiving end of each of the following statements: "You are making me feel angry" and "I am feeling angry." The first is more likely to be felt as an aggressive attack, usually prompting a defensive and unconstructive reply, but the second may well evoke concern to understand more about that particular problem.

The third step is for the couple to agree upon a contract whereby feelings are responded to initially with feelings rather than by intellectual observations about those feelings. It is seldom appreciated how crushing this type of exchange may be. She says, "I am feeling anxious," and he replies, "Don't be silly." It may well be that her feelings are irrational, but even so they are real and important to her at that particular moment. If he responds initially with observations about her feelings, which if he cares for her would probably be, "I feel sorry that you are anxious." This would imply acceptance rather than rejection. Instead of then having to struggle with feelings of rejection in addition to the original feelings of anxiety, she will more readily be able to direct her thoughts towards rational discussion of the particular issue in question, which is the fourth and final step in the "I" language³ procedure. It never ceases to surprise me how frequently even long-standing sexual problems resolve themselves spontaneously after just one session focusing on these particular communication skills, with otherwise little direct discussion of the actual sexual difficulty.

Diagrams of male and female genital anatomy that may be useful in counselling can be obtained free from Educational Services, Division of Chemical and Pharmaceutical Division, Burgess Hill, Sussex RH11 9NE.

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Membership for all?

Entering General Practice. By J S Norell. (Available from Schering Pharmaceutical Division, The Brow, Burgess Hill, West Sussex RH15 9NE. No charge, but to have your name on the College Appoint is invited by Dr Norell, RCGP, 14 Princes Gate, London SW7 1PU.) Those who are busy to qualify for appointment as a principal in general practice, you simply had to have your name on the medical register. It used to be a day to qualify for appointment as a principal in general practice, you simply had to have your name on the medical register. It used to be a day to qualify for appointment as a principal in general practice, you simply had to have your name on the medical register. It used to be a day to qualify for appointment as a principal in general practice, you simply had to have your name on the medical register.

Entering General Practice is more than a well-written résumé of recent legislation. Dr Norell has long experience as a trainer in general practice and has much to say about the organisation and philosophy of

vocational training. I fear that fewer trainers than he imagines measure up to standards. He says many of them agree that "a practice should never be dependent on a trainee; he is after all superannuated, that is, surplus to requirements?" The booklet is aimed at doctors who are considering a career in general practice, but established trainers will find that it contains much that is of relevance to them too.

Dr Norell is dean of studies at the Royal College of General Practitioners and gives an inside view of the College, its examination for membership, and the place of both in today's general practice. Increasing numbers of doctors are taking the College exam; perhaps the booklet will help them to do so. For those who are considering a career in general practice, it is a must. For those who are considering a career in general practice, it is a must.

Sound advice is offered to those who are looking for a practice in these increasingly competitive times and in case you think that finding a practice is the end to all your problems there is a sobering section on the obligations and challenges of partnership. For the keen and academically inclined there is a comprehensive reading list and also a list of useful addresses. It takes only a couple of hours to read this concise but packed, time that he has written, time that he has written, time that he has written, time that he has written, time that he has written.