Audit in Person

Impact of medical audit advisory groups

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Medical audit is a key feature of recent changes to the NHS and is an essential part of the new contract for general practice. Although the term medical audit is used freely, it is necessary to define it. Many definitions have been attempted, but all have in common a systematic critical analysis of aspects of quality of care, reference to standards of care, and commitment to change. Medical audit is not a synonym for traditional review or research activities, as emphasised recently in the report *The Quality of Medical Care* by the government’s standing medical advisory committee in its robust statement that “the essential nature of medical audit is a frank discussion between doctors, on a regular basis and without fear of criticism, of the quality of care provided as judged against agreed standards but in a context which allows evolutionary change in such standards.”

Medical audit for family doctors is complicated by additional audits of their contractual obligations—for example, measurement of procedures for payment. Audit activities must differentiate between contractual audit, which is a management task whose prime purpose is control, and medical audit, which is a professional task with a prime purpose of education. The dividing line between these two types of audit is often blurred, and the skills and resources for each can be shared. Often the crucial difference between the two will be that of intention. An audit of prescribing to exert downward pressure on costs is clearly a contractual audit and a managerial activity whereas the same procedure undertaken voluntarily to develop a logical treatment policy is a medical audit and an educational activity. Any organised medical audit activity in general practice must acknowledge this distinction.

Structure

The formal mechanism for organising medical audit in general practice will be via a new committee, the medical audit advisory group, structural arrangements for which were described in *Medical Audit in the Family Practitioner Services Health circular* (HC (FP)(90) 8). The group will be a committee of the family health services authority, which will appoint its members. There will be up to 12 medically qualified members, most of whom will be general practitioner principals appointed after consultation to ensure that they command the confidence of the profession locally. Appointment to the group will take into account factors such as the distribution of urban and rural practices and the sex and ethnic composition of the local general practitioners. In addition, the group will contain doctors with recognised skill and experience of medical audit. The circular also suggests appointment of a local consultant associated with audit activities in the hospital services and a public health physician. The group will also need to liaise with those responsible for postgraduate medical education, and so the general practitioner members will need to include representatives of the important local and regional educational organisations.


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The group will elect its own chairperson and will be responsible to the family health services authority for:

- Ensuring that all practitioners take part in regular and systematic medical audit
- Establishing adequate procedures to protect confidentiality
- Establishing mechanisms to tackle problems disclosed by audit
- Providing a report on the general results of the audit programme.

All groups should be established by April 1991 to institute regular and systematic auditing involving all practitioners by April 1992.

Process

The ways in which the groups will work will depend on the philosophy underlying the profession’s approach to quality of care. The traditional way has been to identify practices that vary from the norm and eliminate poor performers. It is this model that seems to have inspired some of the thinking behind the proposed establishment of visiting audit teams outlined in the health circular. For many years doctors from the Regional Medical Service visited practices to find out about high prescribing. An alternative is based on theories of continuous improvement, in which good performers are invited to pursue better ways of doing what they already do well. Medical audit should be as much concerned with sharing, publishing, and teaching good examples of care as with exposing bad care. Numerous examples exist of this system in action.1

In the United States, with its already considerable experience of quality assurance, the Institute of Medicine of the National Academy of Sciences has just released a report on quality assurance for the Medicare Program, which has changed its emphasis from utilisation and cost control to an orientation towards continuous improvement in care.2

The management philosophy of the family health services authority will affect the relationship of the medical audit advisory group to individual practices. Many authorities are considering audit networks based on devolution to local units. It is impracticable for a single medical audit advisory group to carry out audit in an authority that may contain over 300 general practitioners, and it will need to set up local advisory groups. The recommendations of the standing medical advisory committee for appointing a local medical audit coordinator3 may be best effected at a level below that of the authority. Only the smallest authorities will be able to stick to the initial outline in the Department of Health’s circular and utilise key members of the medical audit advisory group to work with groups of practices.

All medical audit advisory groups will face common problems.

Meeting—The groups must have a suitable location for meeting and must meet regularly. Apart from work in their own practices, members of the group will have other audit responsibilities, including practice visiting. Active members of the group may have difficulty in meeting their other obligations under the “26 hours over five days” rule for availability in practice. The standing committee’s recommendations that a local medical audit coordinator should have four to five sessions per week will be impossible for full time general practitioners, and efforts should be directed to devising alternative solutions.

Resources—Audit has considerable implications for resources. Estimates from the four pilot family health services authorities that have been pioneering medical audit suggest that £100 000 per year is the likely sum required to provide the infrastructure for audit. Failure of the Department of Health to identify and ring fence money for medical audit in primary care, in contrast with its specific allocation of £30m for audit in the hospital and community services, has meant that most family health services authorities are having to set up medical audit as one of many competing priorities for limited resources. Unless medical audit advisory groups are properly resourced at their inception, audit is likely to remain a peripheral activity. The quality of medical audit achieved will reflect the time available to doctors and depend on the number, calibre, and training of support staff. Audit may eventually identify procedures that are wasteful and release resources for other purposes, but this will be a long term benefit.

Confidentiality—Problems of confidentiality in medical audit have yet to be fully dealt with. The main difference between patients’ records and audit information is that records are about individual patients whereas audit information is about doctors and is often produced in a form that compares doctors with one another. The degree to which this information should be available to the public has not been agreed. In view of the lack of any privilege relating to its subsequent use in legal proceedings, some doctors are recommending that all information retained by medical audit advisory groups be stripped of identifying detail and limited to basic information such as dates, names of doctors attending meetings, topics discussed, and recommendations in general; all other audit papers should be destroyed. Doctors taking part in audit activities should be bound to hold the proceedings in strict medical confidence. Any report that the group makes will have to be phrased in general terms so that no practice or doctor can be identified. There is therefore a difficult tension between the requirements for keeping information confidential and those for looking at identified problems.

Participation—Ensuring the participation of all doctors by April 1992 will not be easy. Although audit is not yet a part of the terms and conditions of service, there is little doubt that the regulations will be changed if appreciable numbers of doctors do not participate.

Outcome

Many groups will start work with a descriptive survey of audit activities already taking place, thus providing initial suggestions for good practice and identifying topics of local interest and concern. The survey will also describe the degree of variation in

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Examples of audit activities for general practice

Practice activity analysis—Collecting data prospectively and then pooling and analysing them to compare individual performances

Case analysis—Retrospective examination of management in a sample of cases

Disease audit—Assessment of performance for disease management against agreed criteria

Consumer surveys—Using patients’ views about aspects of care

Use of routinely available information—Analysis of routine data such as the recently developed service indicators for family health services authorities

Practice annual reports—Their use for audit has been limited, but their future role is likely to be extensive

Critical incident analysis—Regular reviews of selected activities in which an error can be shown to have occurred, such as a complaint from a patient, a visit not logged, or a prescription not issued

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local practice and may suggest a direction for future activities. The group may try to institute one type of audit across the whole district—for example, an audit of the management of a chronic disease—or it may adopt an audit policy for each individual practice. District audit is likely to be favoured by managers, who will be keen to show specific activities in return for the resources provided. On the other hand, practices are much more likely to become involved in auditing topics in which they are interested or concerned. Many possibilities for audit activities exist and these have been well described. The box shows some examples.

The medical audit advisory group will need to report its activities, and these requirements are outlined in the health circular. A report to the family health services authority will be mandatory and will have to be composed with respect for confidentiality. In addition, the group may also inform other bodies with an interest in its findings, including those responsible for service provision and postgraduate education.

In summary, medical audit advisory groups are a new tool for improving medical care, which will need to be introduced with caution. As with all new medical activities, initial benefits in the hands of enthusiasts may be tempered by the subsequent onset of side effects when the activity is more widely applied. There are many concerns about audit, and the groups will need to ensure that audit activities can show effectiveness. Participation in audit is not necessarily the same as achieving change. As with any form of audit, the group will need to monitor its own performance. It is inevitable, too, that from time to time audit activities will fail, and the group will need to be able to assess these failures and give constructive advice. It should also be willing to disseminate ideas about good practice and to provide suggestions for improvements based on local experience. If handled carefully the impact of medical audit advisory groups will be a beneficial influence on the direction of general practice in the next decade.


News and Information

The logic of assessing new and expensive technologies before their general introduction seems to be unassailable, but experience in Ontario shows just how difficult it is in practice (New England Journal of Medicine 1990;323: 1463-7). Three examples are given: introduction of low osmolality contrast media for radiological examinations, use of tissue plasminogen activator for treating myocardial infarcts, and testing populations for asymptomatic hypercholesterolaemia. Because finances were already committed the government refused to fund changeover to the new radiographic medium, but local pressures forced hospitals to do so despite evidence that its selective use in patients liable to reactions would be sufficient. Sophisticated marketing fuelled demand for tissue plasminogen activator, and a consensus conference was only partially successful in limiting its routine use. A working party on cholesterol testing recommended selective screening but was strongly criticised by lipid experts. The authors warn against the oversimplification of issues, the failure to consult widely, the sometimes differing views of consensus groups, and the power of vested interests.

The new contract is likely to require consultants to be more closely involved with outpatients. What happens when a consultant takes over the total running of his own clinics? One consultant decided to limit his plastic surgery clinics in Sheffield and Barnsley to five new patients and 20 follow up patients and to discharge all patients as soon as feasible (British Journal of Plastic Surgery 1990;43: 735-40). Clinic sessions and numbers of new patients fell by 19% and of follow up patients by 50%, but the number of non-attenders also fell, and patients with malignant conditions waited on average four weeks, which seemed realistic if not ideal. Patients with other conditions had to wait much longer, and total consultation rates were found to be just half the average workload in clinics throughout England. If extrapolated to all specialties consultant only clinics would be a formidable challenge.

Thirty four general practitioners with an interest in asthma collected information about inhaler technique from 419 patients in all age groups (British Journal of General Practice 1990;40:505-6). With a simple score of 0-4 to rate adequate preparation before use, proper expiration, inspiratory technique, and breath holding they found that, overall, techniques were inadequate in a quarter of the patients. Whatever the device, a substantial minority performed poorly, but metered inhalers were less well used than those more recently introduced. One suggested reason for this is that patients using older inhalers are less likely to be reviewed, and regular checks are recommended on all patients.

It is generally accepted that early and regular antenatal care results in a more favourable outcome of pregnancy. For this reason Medicaid insurance in the United States has been extended to cover a greater proportion of women in the lower income groups. A study in Tennessee before and after the introduction of insurance cover (Journal of the American Medical Association 1990;264:2219-23) failed to show any improvement in first trimester antenatal care, number of low birthweight babies, or neonatal mortality. The reasons for these disappointing results were thought to be a combination of a lack of knowledge of eligibility; difficulties of access; the limited number of obstetricians willing to provide a service; and factors such as poverty, poor education, and unemployment that militate against such women looking after their health.

Regional audit

West Midlands appointed a retired consultant to coordinate medical audit and to advise the medical audit support group, which consists of six district general managers and clinicians with interest and expertise in medical audit. Districts were asked to set out the committee structure and membership of the organisation for audit locally and any arrangements for cooperation with other districts and were allocated funds by the group accordingly. An account of how the funds have been spent will be delivered to the group by May 1991, and a more structured questionnaire is being developed to gather consistent information from the local committees. Money was retained for training, which is organised by the Association for Medical Education for Clinicians, a collaborative venture run by the regional health authority, Aston University Management Centre, the University of Birmingham Health Services Management Centre, and the BMA; a research fellow at Keele University will be associated with medical audit in the region.

Several medical audit assistants have been appointed. Some hospitals have adopted variants of the regular half day...