Medical audit in general practice

Medical self-assessment programmes, and medical audit also, flourish more, so far, under the aegis of the Royal College of General Practitioners than under the Royal College of Physicians.

Matthews (1979).

THE word 'audit' is unfortunate. Its meaning is not yet universally agreed among doctors and its connotations, both financial and external, cause problems.

The *Shorter Oxford Dictionary* defines audit as "making a systematic examination of" but in this sense medical audit could mean no more than a study, survey, or formal review. The tendency in recent years has been for the word to acquire a rather more precise meaning of measurement of some aspect of performance in relation to a defined yardstick or standard. This concept thus logically links audit with standards.

Standards of care are of interest to all general practitioners but of particular interest to members of the Royal College of General Practitioners who subscribe to the principal object of the College, that is: "to encourage, foster, and maintain the highest possible standards in general medical practice".

Donabedian, from the University of Michigan, USA, has contributed substantially to our understanding of audit. In the struggle to establish standards there are three possible points of entry. The first, and in many ways the simplest, is to examine the structure within which care is provided. Early standards arose in an era of practice organization and concerned premises, staff, and records. The second approach was to examine the process of care and to begin to define what kind of performance could reasonably be expected of a doctor in certain defined situations. Antenatal care was one of the first and the process has been more sharply defined and more consistently agreed in this branch of medicine than in many others. There is probably more unanimity about what a personal doctor should do at a routine antenatal examination in normal pregnancy than in many other consultations in general practice, and the existence of nationally agreed co-operation cards which provide for the records of blood pressure, urine, and weight is testimony to this unanimity.

The third, and in some ways most fascinating, approach is to examine the outcome of care. It can logically be argued that neither the structure nor the process of care are fundamental, and that what actually matters is what happens to the patient. Early outcome studies depended almost entirely on deaths, and infant and perinatal mortality rates are still quite widely used as indexes of care. The specialty of obstetrics has once again led the way and the confidential enquiry into maternal deaths is a remarkable, and at present unequalled, example of a profession critically examining its own performance, whilst rightly guaranteeing absolute confidentiality to colleagues concerned.

Outcome studies have an additional advantage that unsatisfactory outcomes, such as death, can be taken as being bad and the events leading up to them can be considered at leisure. In surveys of structure and process there is always room for argument about whether any particular part of the structure or part of the process is really necessary, or can or cannot be scientifically justified.

In general practice as a discipline, an era of structure has gradually given way to the current fashion of concentration on process, whether physical as in antenatal care, psychological as in the doctor/patient relationship, or in problem-orientated medical records. The unanswered question and one of the challenges for the future is whether in the closing years of this century general practitioners are going to be able, like the obstetricians and paediatricians, to find satisfactory outcome measurements on which to base retrospective studies.

At first sight suitable outcomes are hard to find, but what are coming to be called 'intermediate outcomes', like immunization take-up rates, all give food for thought.

In this issue today we publish a number of articles on the theme of audit which illustrate some of the different approaches currently being adopted. Knowles and colleagues (p. 730) examine diagnoses made by general practitioners on referral to an ear, nose and throat department and compare these with those made by the department itself; MacAdam (p. 723) examines the process of diagnosis of gastrointestinal cancers; and Snider (p. 712) reports the problem of maintaining standards in primary care in the USA.

Ryan and colleagues (p. 719), however, carry out an audit in the more complex definition used above in which defined objectives are subsequently tested in general practice, and Sheldon (p. 703) reports a similar study in which defined prescribing policies or standards are audited in the full sense of the word after a period of time. Finally, Tulloch and Moore (p. 733) from Oxford

report a controlled study of geriatric screening and surveillance in general practice itself.

Donabedian, in his recent Ward Darley Lecture (1979), has classified patient care into two domains, technical and interpersonal, and suggests that quality includes the benefits and risks of both. Medical audit will always be a problem because it implies a formal examination of a process that is inevitably difficult and complex. Nevertheless, the threads are becoming clear and the principles more commonly agreed. External audit by non-doctors is vigorously resisted and generally thought to be diminishing rather than enhancing for a profession. External audit by other colleagues is hotly disputed but becoming more accepted both in the United Kingdom and Canada. Self-audit by individual doctors or practices is now increasingly welcomed and needs to be encouraged.

References

Donabedian, A. (1979). The quality of medical care: a concept in search of a definition. *Journal of Family Practice,* **9**, 277-284.

Matthews, M. B. (1979). Self-assessment programmes and aspects of audit. *Journal of the Royal College of Physicians of London,* **13**, 139-142.

Education in the Northern Region

The College believes that medical education needs radical reshaping to place much greater emphasis on continuing education and medical audit.

Royal College of General Practitioners (1977).

FORMAL postgraduate education for the established general practitioner has been provided, with varying degrees of success (RCGP, 1977), for almost 15 years. Its natal handicap was the absence of a clearly articulated statement of the nature of general practice itself, so that it has not been surprising that, in the main, hospital doctors have decided the content, organized, and taught family doctors.

Clinical tutors have sought advice from general practitioners and encouraged them to contribute: they have been baffled by the lack of response and concerned about the waning interest. General practitioners have struggled to compete with consultants by giving lectures, and have been discomfited by their own inability to communicate in this traditional way, perhaps not realizing that there was a more basic discontent—the method was inimicable to their own interest.

Clinical isolation cannot be dispelled simply by assembling with others to listen to a lecture, however well produced by however eminent a doctor. How often has it been said that "the best part of the meeting was the talk over a drink or a meal"! Any direct relevance to the everyday work of the general practitioner occurred almost by chance and when the shoring provided by the attachment of attendance at Section 63 courses to eligibility for seniority payments was removed, the edifice which remained has creaked and almost crumbled. The returns made by postgraduate committees to the Department of Health and Social Security show a declining attendance rate and study of the content of programmes shows it to have changed but little.

However, this instability may be most opportune, for other important changes have taken place in general practice which should provide circumstances ideal for new initiatives. Vocational training has bloomed with remarkable rapidity. The harnessing of this prodigious enterprise in so short a time will be seen as one of the outstanding medical events of this decade, and it reflects with great credit on the College. The effect on the individual doctor is difficult to assess—those who have tried to assess it rate it doubtful (Thomas, 1978)—but there is no denying the changes which have been wrought in the providers of this educational experience (a better concept than training) and in their practices; they record, meet, discuss, read, teach, and innovate on an unprecedented scale. Its advance has uncovered a previously unexposed enthusiasm of practising family doctors to teach not only their juniors but themselves and, crucially, by critical scrutiny of the records of their own patients in their own practices. Surely some of this must have been absorbed by the transitory trainee?

The survey by Reedy and colleagues, published this month as *Occasional Paper 9,* suggests that it may have been, judged by the ex-trainee principals' expressed preferences for group work and clinical attachments. In addition, ". . . mature general practitioners . . . are seen by younger general practitioners as a legitimate source of information . . ." These signs alone should alert us to a new challenge in continuing education.

It was early awareness of this task that stimulated the North of England Faculty of the College to enquire into the state of postgraduate education in the Northern Region: a questionnaire was sent to clinical tutors following which the ready help of the Medical Care Research Unit was sought to procure detailed information of the interests and attitudes of a random sample of general practitioners. The outstanding response rate of those questioned demonstrated their interest, encouraged the Faculty, and co-incidentally indicated their confidence in Dr Reedy and the Unit. The important conclusions of this report have endorsed the impression of changes produced by vocational training and have served to heighten the Faculty's anxiety about its own organizational inadequacy to cope with a new approach to continuing education. Not for the first