Audit: the need for regulation

THE natural history of new ideas has been aptly outlined as description followed by rejection and abuse and subsequently by regulation (Feinstein, 1967). The story of medical audit vividly illustrates this sequence of events.

The concept of audit, and the use of the term, first occurred in the USA, primarily because of concern about the cost benefit of health care. The same concern has been felt in the UK. A further factor leading to audit has been the emergence, throughout most societies, of a public desire for accountability, especially of the élite. Society and individuals have become less willing to accept passively what is provided, and increasingly express their expectations either in the reports of public committees (for example the Royal Commission of the National Health Service, 1979, and the Committee of Enquiry into Competence to Practise, 1976), in studies by other professions (Kisch and Rudar, 1969; Mechanic, 1969), or through consumer groups.

Audit has been more easily accomplished in the hospital service than in the relative isolation of primary care. Hence, general practitioners have been a particular target of criticism, both from their hospital colleagues, who see their failures and not their successes, and from others. The professional control of standards has been questioned in recent years by both professionals (Brotherston, 1962; Last, 1965; Sanazaro, 1967; Cochrane, 1972; Doll, 1973; McLachlan, 1976) and by others (Friedson, 1970; Klein, 1974; Stimson and Webb, 1975). It is notable that much of this criticism comes from those not involved in clinical medicine. Some of the criticism (Honigsbaum, 1972) has been misdirected because it has been based upon inadequately determined objectives of a medical care programme (Marson *et al.*, 1973). Other criticism has not taken account of recent changes designed to improve the quality of primary care. For example, an underlying assumption in the development of group practice and the primary care team was that both would remove the isolation of the general practitioner and improve communication (Standing Medical Advisory Committee, 1968). Have these assumptions been justified? The difficulties of measuring the results of changes in the method of delivering care when so many factors change have been well documented (Morrell and Nicholson, 1974).

For and against

The concept of audit has generated a voluminous literature. Since 1969, when the *Index Medicus* first began classifying articles under the heading 'Audit', 454 articles have been so classified, including 20 editorials.

The responsible professional bodies have encouraged audit as a way of promoting self-critical care, not only to head off criticism but also to avoid the imposition of an externally imposed system (*Journal of the Royal College of General Practitioners,* 1974).

However, it has been stated that external audit would be unacceptable to the profession (Shaw, 1980) and would lead to the practice of defensive medicine in a goldfish bowl (Stevens, 1977). Even local audit in small groups has been criticized because it is thought that using explicit criteria could lead to a rigid orthodoxy, ossify clinical practice and stifle innovation (Shaw, 1980). It has been reported that audit does not work (McSherry, 1976; Nelson, 1976; Kessner, 1978; *Lancet,* 1976) or is not itself cost-effective (Dudley, 1974).

Audit has been abused because the basic principles of investigation have not always been observed. In any investigation it is essential to:

1. Agree objectives, standards and criteria.
2. Record the data.
3. Interpret the data.
4. Feed the data back to those who collected it.

Unless stages 3 and 4 take place, 'orphan' data will accumulate (Nelson, 1976). But stages 3 and 4 are very difficult if stages 1 and 2 are weak or sloppy. The nature of the feedback mechanism is itself a problem which deserves greater attention (Stott and Davis, 1975).

Definitions

Much of the difficulty surrounding audit arises because there is no universally agreed meaning of the term (*Journal of the Royal College of General Practitioners,* 1979). A detailed study of the articles listed in the *Index Medicus* under 'Audit' illustrates this dilemma; it is difficult to understand why some articles are classified as audit whilst others are not. The objectives of audit are, likewise, confused. The Birmingham Research Unit (Royal College of General Practitioners, 1977) described them as primarily educational. Others have

described them variously as including planning, evaluation of medical care, the measurement of effectiveness and efficiency and the pursuit of knowledge in medicine (Calne, 1974; Hogarth, 1975; Wilson and Larkins, 1977; Duncan, 1980; McCormick, 1981). The jargon which has developed adds to the confusion (Donabedian, 1966; Buck *et al.*, 1974)—audit of structure, process, outcome, internal and external audit, self-assessment and peer review. Mourin (1976) defined audit as including the enumeration of events themselves and the evaluation of one set of value judgments with another.

Methods

The basis of all research is enumeration. Does audit then differ from research? It is important to provide an answer to this question because, firstly, many doctors, perhaps especially general practitioners, regard research as an academic pursuit. They may consequently not submit themselves and their practices to it. Secondly, in primary care particularly, many of the methods currently proposed for audit are so inappropriate that doctors are unlikely to see them as credible (Morrell, 1981).

The basis of any investigation is a critical and enquiring attitude (review). Why does such and such happen? Why not compile your own formulary (Jolles, 1981)? Are my results as good as my peers' and, if not, why not? Is my practice claiming all the item of service payments that it could? However, the translation into action of the idea generated by continuing critical review will depend upon the objectives of the originator of the idea. The objective may be to improve communication within a practice (Stott and Davis, 1975), to evaluate the care of epileptics in a practice (Zander *et al.*, 1979) or to improve the appointment system (Courtenay, 1974). The feasibility and methods required may be simple and well documented. Feedback may not be appropriate other than to the individual or to members of the practice. This sort of audit is surely review, which should be part of the everyday activity of all doctors. However, if the objective of the idea is to define new knowledge or methods, then the study becomes a research project with more complex methods, because feedback is appropriate to a wider audience who may need to extrapolate the data to varied situations. The cost efficiency of new schemes and procedures, with application beyond the confines of a practice or unit, may merit the specialized skills of the community physician. The generalized application is surely a political decision, albeit based upon sound advice by those involved in review and research.

Review and research are part of a continuum with areas of overlap. The division between them is neither hard and fast nor critical. Within this concept, review and research are both parts of audit. Review should be an integral aspect of the daily life of the doctor, as it should be of any successful business. Review may determine the need for research; both are audit or investigation. If either review or research are to be successful, the basic rules of scientific investigation must be applied. In review they may be simple, but should be as objective as possible. In research they need to be applied more rigorously.

Audit in general practice

Primary care has special problems with respect to both review and research. These problems are related to the context and the objectives of the health care programme within which the general practitioner works (Marson *et al.*, 1973). In this context the number and complexity of the variables involved are considerable—so numerous that it makes the task of setting up a data bank for family health studies extraordinarily difficult (WHO, 1976). Howie (1976) has elegantly demonstrated the complexity of the process of clinical judgment in primary care and by implication the difficulty in creating agreed criteria of care. Fry (1975) has detailed the limitations of data derived from even good medical records, and Watkins (1981) has questioned whether attempts to improve recording in a study alter doctors' actions. The cost element in primary care can only be studied for those functions that can be costed (Sackett *et al.*, 1975; Dowie, 1980). Finally, innumerable authors have addressed themselves to the difficult task of measuring the outcome of care in a situation where death is relatively uncommon.

The title of a recent article, 'Medical audit in general practice—fact or fantasy?' (Watkins, 1981), could be interpreted as implying that the problems of investigating primary care are insuperable. This would be unfortunate. It would deter those in primary care from reviewing their work and would inhibit the research which is so desperately needed.

General practitioners have the opportunity of making a major contribution to meeting one of the crying needs of our time, expressed by René Dubos (1966): "The time has come to give the study of the responses that the living organism makes to its total environment the same dignity and support which is being given at present to the science of parts and reactions isolated from the organism." If we are to meet this challenge successfully, then we must encourage review, in particular more objective review. This would not only solve many individual practice problems but should, because of the continuum between review and research, lead to more generally successful research. We can be encouraged by the fact that the majority of trainees have been reported as interested in both review and research (Drinkwater, 1972).

A critical review of their work and research has traditionally been a part of the ethos of medical practitioners. Do we therefore need to perpetuate the use of a term (audit) which simply causes confusion and which is traditionally associated with a profession that deals with figures rather than people?

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Social workers in general practice

SOCIAL workers have the broadly based remit of controlling the resources provided by local social services departments, co-ordinating voluntary assistance and counselling clients. It is in counselling on emotional or social matters that the roles of family doctors and social workers overlap. Such overlap contains potential for both conflict and co-operation between the two professions.

The value of collaboration between general practitioners and social workers is now well recognized, and reports are available from a number of social work attachment schemes in primary care (Williams and Clare, 1979). The importance of such schemes has not been universally acknowledged. What has been acknowledged, however, is that relationships between general practitioners and social workers are generally