FAMILY MEDICINE AND MEDICAL AUDIT

"The physician who sets about to treat a disease without knowing anything about it is to be punished. Even if he is a qualified physician; if he does not give proper treatment, he is to be punished more severely, and if by his treatment the vital functions of the patient are impaired he must be punished most severely."

—Koutilya Arthashastra

Summary

Consumer organisations, community health and other lay bodies are increasing the pressure for accountability of healthcare and this is echoed by cries from within the medical profession. Whatever the misgivings of individual doctors, the formal support being given by professional bodies suggest that medical audit will become established.

Therefore deciding whether you are for or against audit is as meaningless as deciding whether you are for or against rasearch. But unlike research, audit cannot be confined to a small elite, The audit has arrived, its intelligent care can rise standards.

The requirements for audit may be summarised as information, resources and willingness to participate. The principal ingredient is one's willingness. The audit should be comprehensive, continuous and dynamic and beneficial to patients.

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How frequently we disclose our auditor's duty may determine how long we determine the privilege of judging our own performance according to minimally restrictive guidelines. Complacence could well lead to action from outside the profession.

> *''There are two types of physicians:*
> *Those who promote life and attack diseases,*
> *Those who promote diseases and attack life".*
>
> *—Charaka Samhitha*

Introduction

The problem of medical audit has been discussed at length recently in the medical press and the point has been, that the medical profession should be made answerable in part, for the standard of its own treatment, the main object of audit being, to maintain or improve medical standards. Therefore, hospital administrators, medical staff, governing bodies and medical associations, including that of general practitioners have come to view medical audit with increasing concern.

Definition

'Audit' has been defined by Oxford Dictionary as 'making systematic examination of", 'Official examination of accounts'. The word 'audit' like audition implies having inquiry or survey, that is conducted not simply for academic interest, but in order to measure some thing against a standard. Hence the medical audit is a review of the professional work and is concerned with standards and effectiveness of medical care.

The functions of medical audit are monitoring and upgrading standard of health. 'The concept may be broadened to identify doctors who have a poor performance and monitoring their performance' (Editorial, BMJ 16th Apr. 1980,286 :1229).

Historical

With the advent of hospital standardisation (1981) one major requirement was a regular review and analysis of clinical work of the

hospital by the medical staff. Even before the American College of Surgeons commenced its work on hospital standards, Dr. Ernest Codman of Boston enthusiastically emphasised the fact, that the professional efficiency of the hospital could not be properly evaluated without good records and a study of end results. In 1981 Dr. George Gary Ward, a noted gynaecologist of New York emphasised the importance of good medical records and gave for the first time, an organised medical audit of all his patients. Dr. Thomas Ponton (1928) presented a plan called 'Professional Service Accounting' which has been the basis for the thorough evaluation of professional work of each member of the medical staff and hospital as a whole.

Justification for Medical Audit

> "One who treats without knowing anything, and making tall claims is certainly to be punished".
>
> —*Manu Smruthi*

The medical audit can be justified on the basis, that it is a stimulus to the practice of scientific medicine and an objective and a specific check on professional work. It can be compared with the financial audit.

If it is important to have an audit on rupees and paise, is it not now more important to have an audit of the professional work of general practitioners and an account of medical care rendered, in terms of life saved, avoidable and unavoidable deaths, diseases arrested, and perhaps rehabilitated and restored to society as happy, healthy and productive people? General practice also needs medical audit in some form to ascertain, among other things whether they treat too few patients or too many.

Medical audit will always be a problem because it implies a formal examination of process, that is inevitably difficult and complex. Nevertheless, 'the general practitioner who never questions what he is doing is nearly dead from the neck up that he is beyond the reach of an external stimulus" (leading article, Lancet 5th 1980 1: 23).

Why Widespread Reluctance to Medical Audit?

General practitioners are notoriously individualistic and resent invasion of their privacy. Also doctors may not believe that clinical audit, including peer review really works and that it can be of benefit to the profession.

They may not accept that audit can identify doctors who are in most need of guidance and help and they are also reluctant to take part in the procedure that seems like judging colleagues. If poor performere are identified, this will destroy the general confidence and trust the patients have in thier doctors—making the exercise self defeating. Even if such poor performers were identified, there is no way of remedying matters under the current system. But the truth is, patient's trust in their doctors might be increased by the knowledge, that the profession is putting its own house in order (Editorial BMJ 16th April 1980).

Why Audit?

> "Whenever the quality of care has been examined, serious and wide spread deficiencies have been found".
>
> *—Donabedian A., University of Michigan*

Mistakes result usually not from lack of knowledge but more from its disordered application. Clinical impressions are notoriously unreliable and most doctors have their own ideas, built up over years about common clinical entities, based more on impression than on facts.

Hence medical audit should be a subject of increasing concern for general medical practitioners whose aim is "to encourage, foster and maintain highest standard in general practice" (Editorial. JRCP Dec 1979; 29 :699).

The debates on audit centres on two main questions:

1. Is effective audit possible?
2. Should it be self imposed or should it be externally imposed? Either voluntary or compulsory?

For some aspects of general practice audit is clearly possible (Obstetrics-maternal and perinatal mortality and morbidity, detection and control of diabetes and hypertension). The trouble with such a list is, that disorders are usually chosen, because they necessarily reflect the essential clinical skills and humanitarian qualities at the centres of good general practice.

Phases of Medical Audit

Actually there are two phases to the medical audit. First, there is

the medical accounting, that is, the providing of adequate records of performances as a basis of analysis. Just as we have accurate recorded data in the financial audit, so must we have that data for medical audit in accurate and complete records. Thus one of the main essentials of an audit is that the records on which it is based must be accurate and upto date, perhaps even more important—the results must be honestly recorded. A study of case notes cannot produce good data when the notes themselves are so often inadequate. One problem in arranging such a survey, is the time required to gather and record the facts for each case. Time is money.

The other phase of the medical audit is the actual analysis of recorded data in the clinical records—the filed reports pertaining to the professional work of the general practitioner and other related information.

Audit by Whom?

Audit in general practice appears more difficult to set up than audit in hospital practice. The million dollar question is who should do medical audit? Should the audit be by patients supervisors? or our peers?

Methods of Medical Audit:

1. By a Physician Specialised in Medical Audit

He comes to the general practitioner once or twice a year to examine the professional work and gives a confidential report with regard to the quality of work being performed. However, at present there are few qualified physicians doing this work on a full time basis.

2. Peer

By a committee representing the major clinical services known as the medical audit committee. These members are carefully selected physicians who have good judgment and are frank, fearless and without prejudice. They must be well skilled in their respective area of performance. Such an audit is conducted periodically.

3. External vs. Internal Audit

Not because attempts to improve external audit would almost certainly fail, but much more because the only kind of audit that is worthwhile is

nothing more or less than application of continuous critical inquiry into every aspect of running a general practice. It can only be internal audit and should preferably be voluntary.

There is probably a small place for external audit in a few procedures like immunisation programmes, planning and encouraging internal audit.

Benefits

The maximum benefit of auditing is realised only when differences undergo repeated scrutiny through follow up studies. The strength of the medical audit lies not only in uncovering the clinical problems but also in the subsequent evaluation made in correcting the problems. Auditing procedures should be repeated to ensure achievement of desired goals.

Topics of Audit

A topic of audit should preferably be a common well defined, clinically significant diagnosis or treatment, where management has a clear effect on the outcome.

Though not all aspects of medicine lend themselves to audit, this does not diminish the value of what is learnt from those that do.

In general practice the topics of audit could be:

1. To examine the structure within which care is provided, practice organisation, concerned premises, staff and records.
2. 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 eg. antenatal care.
3. To examine the outcome of care eg. deaths, infant and perinatal mortality rates.

Examples of Topics

Hypertension, diabetes, thyroid disease, ulcers, otitis media, pyrexia of unknown origin, surveillance of elderly at home, backache, urinary tract infection, depression, information records.

Conclusion

The purpose of medical audit should be educational and shown to be relevant to the patient care. Participation in medical audit should be voluntary and spontaneous and the standards should be set locally by participating general practitioners and methods used should be non-threatening, interesting, objective, repeatable for follow up. The resources should be cheap and simple and cause minimal disturbance to clinical work. Adequate clinical contact and referral systems are also very essential.

The process of audit rests on a habit of mind that needs to be instilled early in the career of medicine. The habit of continuously questioning medical customs and procedures needs to be cultivated so assiduously that it lasts at least until the onset of senility. The responsibility of effective informal audit rests squarely on the shoulders of universities, the medical colleges and perhaps above all on those responsible for post-graduate training and general practice.

Without a willing spirit of enquiry, audit is worthless.