Working papers in medical audit

As, then, the physician ought to be called to account by physicians, so ought men in general to be called to account by their peers.

— Aristotle

When the topic of working papers is raised in medical circles there may be one of three typical reactions:

- "What are they?"
- "They are of no importance anyway. What on earth is the fuss about?"
- "We are making a rod for our backs. They must be destroyed at once."

Well, what are working papers? Are they of no importance? Could they, indeed, be a major medicolegal hazard to ourselves and our colleagues in the future?

Medical audit, or peer review, has existed for 2500 years or more, but working papers have not. Medical audit was an informal process in Canada until recently, when the Canadian Council on Hospital Accreditation decided that such a mechanism must be formalized and made available for scrutiny.[1] Ostensibly the purpose is to enhance the scientific and educational value of medical audit. However, medical care is now financed by the government and accountability is a key concept. Medical audit — appraisal of the quality of health care — is a facet of such accountability and must not only be done, but also must be seen to be done; hence the formal mechanisms.

Working papers are the first documents to be produced in a medical audit: they are the first abstraction from the patient's medical record. Mortality reviews contain opinions on the quality of care given by the attending physician and the reasons for such opinions. The working papers of criterion-based audits are documents produced by the medical librarian. Such documents list the criteria, the patient's medical record number and the code number of the attending physician. They provide information concerning not only the criteria met in a particular patient, but also the criteria that patient's physician met in giving care generally to patients and the criteria met by that physician's colleagues working with supposedly similar patients in the same hospital under the same conditions.

The fate of working papers depends on the administrative structure of the hospital. If the administrative staff includes chiefs of services, the working papers of mortality reviews are sent to them. If this is not the case, the papers are sent to the chairman of the medical audit committee. The working papers of criterion-based audits usually remain in the medical records department, although the librarian sends a second set of papers, which includes an assessment of the overall service or hospital treatment, to the chief of the service involved or to the chairman of the medical audit committee. The chief of the service reviews the results and reports to the medical audit committee.

What is the importance of working papers? They contain the opinions of the peers of a readily identifiable physician on the quality of care given by that physician to a readily identifiable patient. These opinions are explicit in mortality reviews and implicit in criterion-based audits.

Many individuals in the medical profession believe these working papers to be private documents, the property of the chiefs of services or the chairman of the medical audit committee. As such, they should be disposed of as those individuals see fit and not be subject to court order. If this were so, the working papers would be of little importance. In fact, working papers are generated by formal hospital administrative processes. They are the property of the board of governors and are subject to court order. Indeed, even if they were private documents of chiefs of services or the chairman of the medical audit committee they would still be subject to court order.

The position of the individuals taking part in the auditing process is unenviable. It is often assumed that medical auditors are protected by law, as is stated in the Public Hospitals Act.[2] However, they are protected only against legal action taken by colleagues for damages resulting from negative decisions made during the auditing process. They are not protected from subpoena by the courts. Indeed, medical auditors may have to give evidence in court, disclosing details of discussions that occurred during the reviews and enlarging upon opinions given and why they were given.

Is it likely that medical auditors will be subpoenaed by the courts to present their working papers? It has been argued that this has never before happened in Canada, so why should it happen now? This argument should be accepted only with great caution because circumstances have recently changed considerably. First, auditing processes have become formal with the production of working papers. Second, the existence of such papers is now becoming known to members of the legal profession, who ethically have to advise their clients on all matters in their clients' interest. Finally, litigation against physicians is increasing. Fortunately, we are not yet in the position of our colleagues in the United States, but we are heading in the same direction. It can also be argued that even if a medical auditor were to be subpoenaed by the courts — in fact, one member of a medical audit committee has been subpoenaed to give evidence in a case against a colleague — the auditor's position would be no different from that of any other expert witness. However, although this argument is plausible, it is specious. Members of an audit committee are in a unique position as far as the court is concerned. They are a defendant's peers. The evidence given by such individuals is worth far more to the court than that of an expert witness from another hospital in another area. It is a widely recognized and accepted principle that, according to the facil-

ities available, what might be an acceptable standard of practice in one hospital is not necessarily feasible in another.

Why should such evidence not be available to the courts? Wouldn't justice be more readily served if it was available? Assuredly such evidence should not be available. Although we in the medical profession are not in the business of protecting each other from litigation, neither are we in the business of making litigation against our colleagues easier or of increasing the chances of its being successful. It is notoriously difficult for lawyers to persuade colleagues in a hospital to give evidence against each other. However, if the working papers are kept they are readily available to a lawyer in discovery proceedings, and the subpoena of those involved in the auditing process will be inevitable if the opinions they gave in the working papers were negative. The irony of the situation is that the more candid and forthright the opinion, motivated by the prospect of scientific advancement or the education of the physician concerned, the greater the medicolegal jeopardy in which the physician's colleagues have unwittingly placed him or her.

There is further danger implicit in criterion-based audits. The criteria are drawn up by the hospital staff and represent guidelines for an acceptable standard of practice. However, such a flexible set of guidelines could all too quickly become, in the eyes of the courts, a set of procedures that should have been adhered to. The more explicit the criteria stated in a particular audit the more readily they will be interpreted in this manner. Yet such explicitness may be desirable in some audits in the interests of education and scientific advancement.

Why not, then, destroy the working papers when their educational and scientific purpose has been served? They are not required for accreditation purposes and it is not illegal to destroy them. In one legal counsel's opinion this would be a most unwise procedure (R.A. Little: personal communication, 1978). He considered that it would be difficult to explain the reason for destruction to a judge or jury should such working papers be sought and should it become clear that they had been destroyed as a routine procedure. Indeed, the impression might well be given that the purpose of the destruction was to protect the hospital and its staff. In this event, doubt would be cast on any evidence presented by either the hospital or a member of its staff. In an extreme instance a chief of service, the chairman of a medical audit committee or a hospital employee could be held in contempt of court if the destruction of such working papers occurred when the individual had reason to believe they would be required in a legal proceeding. If this view is widely shared by the legal profession, and there is every reason to believe that it is, hospital boards are now in a most embarrassing position.

What, then, is to be done? Do we audit our work with the possibility uppermost in our minds that the working papers may be used for litigation purposes? Criticism, even by implication, and negative opinions would be avoided whenever possible, and generally would be confined to judiciously worded suggestions for possible alternative management. Criterion-based audits would include as few explicit criteria as possible. Contentious areas, such as outcome, would be avoided on the grounds that so little is known about the natural history of that particular disease. In a word, peer review would become a farce. This would be tragic because much damage might be done to the profession's attitude towards peer review. Most physicians readily accept the responsibility for their ongoing education. This is most apparent in their readiness to ask for a colleague's opinion and help, and in their acceptance of constructive criticism and suggestions. This type of peer review has gone on for centuries, and is probably, in the long run, the most educational and therefore the most effective auditing process. This attitude ensures that such consultation continues and is therefore the best guarantee of high-quality patient care. Anything that undermines this attitude or tends to reduce the exchange of candid and forthright views between colleagues should be deprecated and its introduction resisted.

What, then, is the alternative? Surely the Canadian Council on Hospital Accreditation should stop putting the cart before the horse, and should stop demanding that doctors audit their work in this formal manner until the provincial governments have introduced suitable legislation to protect the individuals involved in the appraisal of the quality of health care, and the working documents they produce, from subpoena by the courts. Such legislation is not without precedent. In the United States, statutes have been enacted in 39 states that provide some form of immunity to individuals involved in hospital and medical staff review committees.[3]

If we act now to bring pressure to bear on the council we may not be too late. Otherwise, we should know what we are doing. In the short term we will have the approval of our mentors, but in the long term our actions will be a grave disservice to ourselves, our colleagues and our innocent and hapless patients.

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