Medical Audits

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Although the idea of medical audits has existed for some time, very few hospitals or medical groups have initiated them and some doctors consider them useless or harmful. That it should be advisable to monitor the medical care given to patients would appear unquestionable; how best to do it poses a difficult problem.

On the Medical Unit at the Queen Elizabeth Hospital we have held a regular audit for the past 18 months and have found it to be an enjoyable and worthwhile procedure. Audits are held weekly at lunchtime and involve five consultant physicians and their junior staff, including final year students. Once a month all deaths occurring in the previous month are reviewed; in the other weeks a random selection of case notes of recently discharged patients is looked at. The reviewer audits notes of patients who have not been under his own care. Obviously the number of cases reviewed at the 'death' audit varies from month to month but is usually about two for each consultant. At the other audit each consultant reviews three sets of notes, which means that each month the notes of approximately a quarter of all discharged patients are reviewed. The meetings last one hour and each auditor has 10 to 15 minutes to present the cases, or about 5 minutes a case. To facilitate the audit the reviewer completes in advance a form that asks specific questions covering all aspects of patient management.

The pro-forma covers details of admission, documentation, investigation and treatment of illness, patient education and welfare, and discharge.

Examples of questions asked are:
Were initial medical notes adequate?
Was the subsequent course of the illness well documented?
Number of emergency investigations? Number unnecessary?
Number of non-urgent investigations? Number unnecessary?
Was initial treatment appropriate?
Were any drugs used inappropriately?
Was it clear from the notes what information was given to patient and relatives?
How many days after discharge was summary sent?
Are follow-up plans clearly stated?

With 'death' audits the main emphasis has been on patient management and whether death might have been avoided. After the presentation of the case a short discussion is held and, where necessary, the managing consultant or his staff are given a chance to defend themselves.

Perhaps the most important observation when we started the audit was the poor quality of our notes. Almost without exception it proved impossible to comment on patient management because of inadequacies particularly of the follow-up notes. Also absent were any written statements of policy and of information given to the patient. Shortly after audits were initiated, these omissions were corrected, the quality of notes improved immeasurably and has been maintained at a high level.

The other major defect disclosed was the inordinate delay in getting the final discharge letter to the GP, particularly for patients of two of the consultants. Although improvements have been made, they have been much more difficult to maintain. Delays have been caused predominantly by the doctor producing the summary and rarely at secretarial level. Other points to emerge have included over-investigation and over-treatment, but hardly ever under-investigation or under-treatment. Whether audits have reduced these defects it is impossible to say, particularly as there has sometimes been disagreement as to whether management was appropriate or not.

The audits have proved popular among both consultant and junior staff. Initial fears of a 'witch hunt' were soon dispelled, although a degree of apprehension exists in each team when one of their cases is about to be examined. We have felt it essential for the consultant to be present at the meetings whenever possible, although in his absence a senior member of the junior staff has deputised. We thought that it might sometimes be difficult for a junior member of staff to criticise the consultants, but have been encouraged by the ease with

which this has happened.

It is difficult to be certain whether our audits have significantly improved the care of our patients. We feel that the vastly improved documentation of our cases has been beneficial. This is perhaps of greatest importance at night when doctors who do not know the patient may be called to advise on management.

Awareness that we might be required at a later audit to explain or justify our investigations or treatment of a patient has led to more critical thinking about these problems while the patient is in the ward. In particular we feel we have reduced the number of unnecessary investigations, especially those carried out as emergencies at night.

Audits have emphasised that proper communication with the patient and the relatives is an integral part of management and have ensured that what has been said is documented in the notes and the information transmitted to the GP in the discharge summary.

We plan to continue with the audits, as it seems likely that the improvements achieved will be maintained only by constant scrutiny of our deficiencies. With the virtual eradication of the obvious defects in the notes, our meetings have tended to become rather repetitive. To avoid this, changes in the meeting will be necessary and in particular we would like to devise methods for more obviously assessing 'patient care'. The subjectiveness of this poses problems, but there is scope for discussions on rational drug therapy, and policies for the management of common problems. Another area that might be explored is the assessment of the patients' thoughts after a stay on our wards; this may bring to light defects of which we are unaware.

We have been encouraged by the comments of visiting doctors who have been impressed by the format of our meetings. We feel that many other units or hospitals would benefit from setting up similar audits. The essential features of a useful audit appear to be the desire to improve medical management and the ability to accept open criticism of oneself or one's team. We have demonstrated to our own satisfaction that audits are useful and, despite much criticism of one another, have managed to remain friends.

Book Review

Dermatology for the Physician; an illustrated guide by E. L. Rhodes. Bailliere Tindall, London, 1979. 112 pages. Price £8.50.

Skin diseases induce a sense of excitement in general physicians when they signify the presence of systemic disease or they may seem merely vexatious when, in the course of a consultation for another problem, the patient decides to seek advice for a skin condition. As a result, most physicians acquire some skill in dealing with skin diseases but are often baffled when confronted with the less common conditions and need a handy, well-illustrated reference book to help sort them out.

An author has to decide whether to concentrate solely on those dermatological conditions that are markers for systemic disease or to write a broader account covering material found in the specialist textbooks but to slant it towards the needs of the general physician. In this book the author devotes roughly one-third to skin disease as a manifestation of systemic disease and the remainder covers what is conventionally regarded as the province of the dermatologist. The difficulty of deciding what to include is best illustrated by the example of Hailey-Hailey disease. No doubt general physicians would misdiagnose this condition as seborrhoeic dermatitis if they ever encountered it, but it enjoys a disproportionate amount of text in relation to its importance while intertrigo, a far commoner condition, is not mentioned. With an eye to overseas sales, tropical diseases are included, but are they really worth incorporating in this short book?

However, in 104 pages the author has managed to cover an extraordinarily broad range of common and rare skin disorders. To fit text and 162 illustrations into a book of this length and dimensions, many of the illustrations have had to be greatly reduced in size. Only an occasional illustration has suffered in the process (e.g. Fig. 3), but the majority have been well reproduced in excellent colour and with good tonal qualities. An elegant layout on a black background makes this an attractive atlas to use. Sound practical advice on diagnosis and management can be found adjacent to the illustrations, but unfortunately the text is marred by an unevenness varying from the banal ('The causes of blistering are many') to the cryptic ('suspicious lesions should always be referred to a dermatologist before they have obviously become malignant'). The general reader will find these and similar statements not only unhelpful but irritating and distracting.

Developments in dermatology are dealt with peremptorily; for example, there is no explanation of the author's misgivings about the use of ultraviolet light and psoralens in the treatment of psoriasis. Where the author's views are set out clearly and readably she conveys much practical information, but the greatest strength of the book lies in its illustrations. Anyone needing a cheap, well-produced and easy to handle atlas with memory-jogging notes would find this a reasonable choice.

B. J. Kirby