Medical audit: the differing perspectives of managers and clinicians

ABSTRACT—The objectives of this study were to gauge the attitudes and perceptions of managers and clinicians to medical audit, and to identify differences which might be barriers to the effective implementation of audit. A questionnaire survey of consultants and health service managers in one health district was conducted prior to the introduction of medical audit. Replies were received from 113/144 (78%) clinicians and 53/70 (76%) managers. Managers and clinicians concurred about the potential benefits of audit but had divergent opinions regarding its disadvantages. Seventy-one per cent of clinicians thought that audit would interfere with clinical work and 41% that audit would consume resources that could be better used on patient care. Only one in eight managers shared these views. Clinicians were divided on the threats to clinical autonomy and were three times more likely than managers to agree that audit would enable managers to influence medical practice. Most clinicians considered that audit would require one session a week, while 49% of responding managers thought audit could be performed within existing timetables. Although managers and clinicians are broadly in favour of the introduction of audit, they differ in their assessment of the time required and the opportunity costs. Appreciation of these differing perspectives should facilitate the effective introduction of audit.

The requirement to introduce medical audit in all hospitals performing NHS work by April 1991 has been welcomed nationally by the professional bodies representing clinicians and health service management [1]. Audit had previously been conducted voluntarily by some doctors but it is now a compulsory universal activity.

The guidelines prepared by the Royal Colleges and their faculties have assisted clinicians to meet the government's deadline, but the steps from national edicts to local implementation are many and complex.

An effective system of medical audit requires three essential elements: agreed criteria for good practice; methods of measuring performance against these criteria; and mechanisms for implementing appropriate change in practice [2].

The setting of standards is primarily the responsibility of clinicians, but the two other components of audit are highly dependent upon co-operation between doctors and managers. Managerial involvement is needed for measuring performance because there are resource implications; doctors need protected time in which to do it, and they need staff and information systems to support them. Managers are key players in facilitating changes in current practice to correct any shortcomings highlighted by audit. Clinicians acting alone will be able to influence individual professional performance and initiate minor operational changes, but the help of general management will be needed for corrective actions that require additional resources or changes in the working practices of non-clinical staff.

In order to gauge the attitudes of managers and clinicians to medical audit, and to identify differences in perception which might be barriers to the effective implementation of audit, we have conducted a questionnaire survey of all consultant clinicians and health service managers in North Staffordshire health district.

Methods

We sent a semi-structured questionnaire to all consultant staff (39 physicians and 105 other clinicians) and to all members of district and unit management boards (n = 70) in North Staffordshire health district during the spring of 1990. Reminder letters and duplicate copies of the questionnaire were sent to the same people four weeks after the initial mailing.

The questionnaire contained nine statements about medical audit. Respondents were asked to indicate the extent of their agreement with each statement by checking one of four boxes: strongly agree, agree, disagree, or strongly disagree. They were also invited to elaborate on their responses with comments if they so wished.

Responses were anonymous, but were identifiable by broad clinical specialty or by seniority of management. However, for analysis, responses were grouped as 'physicians', 'other clinicians', or 'managers'. The results were analysed by χ-squared cross tabulation statistics, using SPSS/PC+ on a microcomputer [3].

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Results

The overall response rate was 78% (38/39 physicians (97%), 75/105 other clinicians (71%), 53/70 managers (76%)). The pattern of responses of physicians and other clinicians was very similar with no statistical difference between these two groups on any of the statements (Figs 1–4). For further analysis, the responses of all clinicians were grouped together and compared with those of the managers. Virtually all respondents expressed an opinion on each of the questions. In the following analysis, the denominator for percentage agreement/disagreement is the total number of respondents in each group (113 clinicians or 53 managers).

Benefits of audit

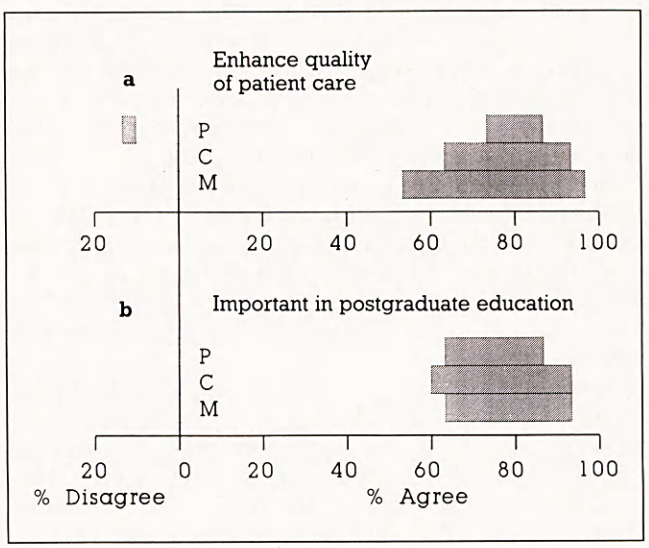
Almost all clinicians and managers agreed that the introduction of medical audit would enhance the quality of medical care provided to patients (91% and 98% agreement respectively). Similarly, 90% of clinicians and 94% of managers agreed that audit would be an important component of continuing medical education (Fig. 1).

Disadvantages of audit

There was widespread concern among clinicians (71%) that audit would interfere with their routine clinical workload (Fig. 2). This view was not shared by managers (11% agreed, 85% disagreed, 4% had no opinion) ($p < 0.0001$). A minority of respondents considered that audit would be a waste of effort. More clinicians (15%) than managers (2%) held this view ($p < 0.01$). Five clinicians (4.5%) gave no reply to this question.

Forty-one per cent of clinicians agreed with the statement that audit will utilise resources that could be more appropriately used for patient care. Only 13% of managers shared this view ($p < 0.001$) while all seven general managers disagreed with this statement (Fig. 2).

Fig. 1. *The percentage of responding physicians (P), other clinicians (C), and managers (M) who agreed or disagreed:* ***a*** *that audit will enhance the quality of medical care;* ***b*** *that audit will be an important component of continuing medical education. Strong agreement or disagreement shown by shaded areas.*



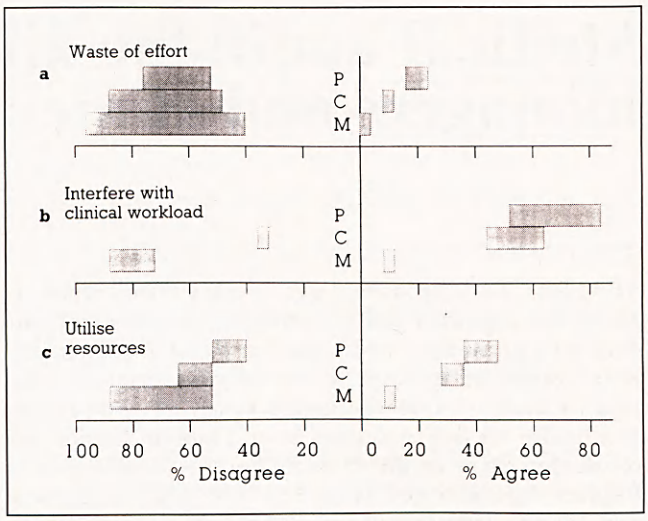


Fig. 2. *The percentage of responding physicians (P), other clinicians (C), and managers (M) who agreed or disagreed:* ***a*** *that audit will be a waste of effort;* ***b*** *that audit will significantly interfere with routine clinical workload;* ***c*** *that audit will utilise resources that could be more appropriately used for patient care. Strong agreement or disagreement shown by shaded areas.*

Audit and clinical autonomy

Two statements related to the impact of audit on clinical autonomy. The clinicians were more divided on this issue than on any other. Equal numbers of clinicians agreed and disagreed that audit would enable managers to manipulate medical practice (48.7% agreed, 48.7% disagreed, 2.6% had no opinion), while 36% considered that audit would restrict clinical autonomy (Fig. 3). Most managers (85%) felt that audit would not affect clinical autonomy, while 83% thought that audit would not enable managers to manipulate or influence medical practice ($p < 0.0001$ and $p < 0.01$ respectively).

Time requirements for audit

The majority of clinicians (74%) thought that audit would require one session per week if it were to be adequately performed, and 80% considered that audit

could not be successfully carried out outside their normal clinical sessions (Fig. 4). Responses from management were more evenly divided: 40% agreed that audit required one session per week, while 49% thought that it could be performed within the constraints of existing timetables ($p < 0.001$ for both statements).

Discussion

This survey demonstrates that both managers and clinicians believe medical audit to be a 'good thing', but they have divergent views on the implications for services and for time and resource requirements.

Successful medical audit requires a corporate commitment from clinicians and managers for both its introduction and ongoing support. Knowledge of what doctors and managers consider to be important is crucial in shaping an approach to introducing medical audit that will minimise conflict and maximise the chances of success.

Although the physicians at the North Staffordshire Hospitals Centre have held monthly audit meetings since 1979 [4], new audit methods are being introduced in response to the White Paper proposals. At the outset of this study it was our hypothesis that the physicians' previous experience of audit might make their responses different from those of the other consultants. However, the study demonstrated virtually identical patterns of response in these two groups.

The potential for improving quality of patient care and educational benefits have featured widely in the justification and rationale for the introduction of audit. The major theme of the White Paper *Working for Patients* was one of improving quality of patient care [5]. For the profession, one of the main reasons for embarking on audit is to enhance postgraduate education, and the Royal College of Physicians considered this to be the single most useful product of audit [6]. On these issues, clinicians and managers form an alliance in favour of the introduction of medical audit, despite the paucity of formal evaluation of its effectiveness and efficiency. This lack of objective evidence was the main concern among the small group of respondents (7%) who disagreed with these statements.

Evidence of divergent viewpoints emerged more clearly when the potential disadvantages of audit were considered. Many clinicians were concerned that audit would interfere with clinical activity and divert resources that might be better used for patient care. Managers did not share these reservations, perhaps because managerial support for the introduction of audit may stem from a desire for greater efficiency in the use of resources, while the clinicians' primary concern is for quality of individual patient care [7].

The active and direct participation of clinicians is a basic requirement of successful audit [8], and concern has been expressed as to the value of audit with reluctant participants [9]. Despite recognising that audit may interfere with clinical activity and will have opportunity costs, the majority of the responding clinicians nevertheless felt that it would be a worthwhile activity. Given that this survey was conducted prior to full-scale introduction of medical audit, it is encouraging that most clinicians appear to be willing players.

Clinicians and managers differed in their concepts of the time needed for medical audit. The amount of time that should be devoted to audit has been controversial and remains an unresolved issue. There is a threefold variation in published estimates of the time

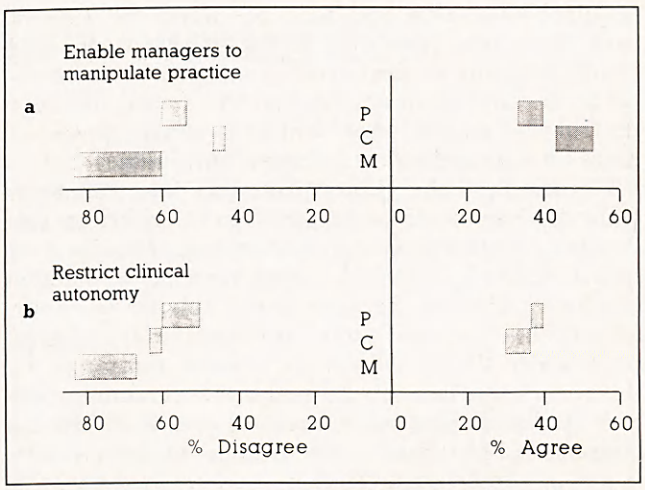
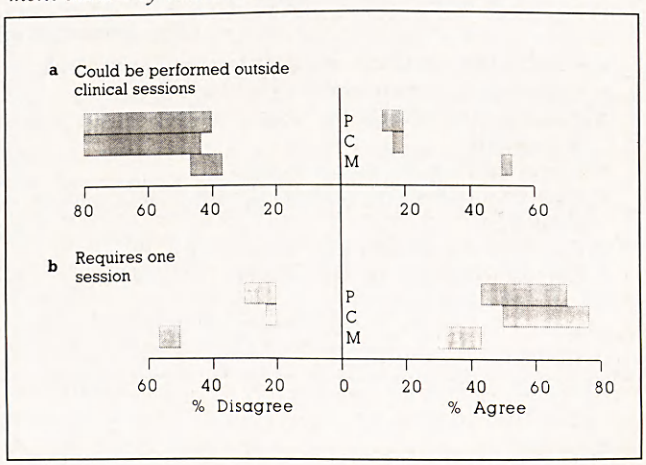


Fig. 3. *The percentage of responding physicians (P), other clinicians (C), and managers (M) who agreed or disagreed:* ***a*** *that audit will enable managers to manipulate medical practice;* ***b*** *that audit will restrict clinical autonomy. Strong agreement or disagreement shown by shaded areas.*

Fig. 4. *The percentage of responding physicians (P), other clinicians (C), and managers (M) who agreed or disagreed:* ***a*** *that audit may be effectively performed outside normal clinical sessions;* ***b*** *that audit will require one session per week if it is to be performed adequately.. Strong agreement or disagreement shown by shaded areas.*



required—between one hour per week and 10% of each clinician's time [10]. As the present survey was conducted prior to the introduction of universal medical audit, time requirements had to be estimated, but the survey suggests that clinicians expect to spend more time on audit than managers anticipate.

Clinicians in the United Kingdom have far more clinical autonomy than do their North American colleagues. At present, British doctors are not subject to formal review by licensing bodies, their peers, or their employers. Perhaps because of this relative freedom, anxiety about medical audit has sometimes been based on concern that it will reduce clinical autonomy. In the present survey, several respondents who considered that audit was not a threat to clinical autonomy commented that audit was, in fact, the best way to maintain professional freedom, and claimed that the conduct of audit will enable doctors to demonstrate proficiency and thus resist external regulation of the profession.

In conclusion, this survey indicates common ground between managers and doctors regarding the benefits of audit, but reveals several areas of divergence when the downside is considered. The successful management of change requires recognition of such differences: effective introduction of medical audit will be easier if both groups are aware of the nature and extent of their differing perspectives.

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