LETTERS

Routine data: a resource for clinical audit?

The recent review by Martin McKee¹ makes several important points but also raises one issue which needs further discussion. This concerns the definition of "routinely collected data" which he proposes: "data whose primary reason for collection is other than audit." It is implicit in the paper that the definition refers to data which are collected regularly and over an extended period. However, omitting these concepts from the definition leaves them unqualified. For example, would a system which regularly gathered data on, say, 10% of patients count as routine, or is this definition limited to systems covering all patients? Similarly, how long need the period of collection be: should it be open ended or does the definition include systems planned to collect data for only one or two years?

There is a more serious confusion which arises from this definition. It leads to systems such as the Lothian² and North West Thames³ surgical audits, which have collected data on every patient seen for an extended period, being described as "non-routine." The problem arises because "routine data collection" is defined in terms which do not relate to the way in which the data are collected but only to the reasons for their collection – that is, data which were initially collected for reasons other than audit. As such the definition does not follow the convention of "describing a thing by its properties"⁴ but uses instead the motives of the unseen planners of data gathering. What happens when, as is often the case with large scale data collection systems, there is more than one motive behind the data gathering: how do we decide which is the primary one? Equally, what if several people with different motives are involved in the design of the system: whose motive is to be considered paramount?

A further distinction needs to be made about the reasons for data collection, that of ownership. For some systems, such as those in pathology or pharmacy, data are requested, processed, and used by the health professionals involved in their collection. However, for other systems, such as the Körner minimum data set or cancer registry returns, data are provided by health care professionals for official purposes. Thus the purpose for which data are collected is more complex than simply whether they are to be used for audit. There is a need for a standard definition which covers all dimensions of routine data: purpose of collection, ownership, and the features of the collection process.

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- 1 McKee M. Routine data: a resource for clinical audit? *Quality in Health Care* 1993; 2:104–11.
- 2 Gruer R, Gordon DS, Gunn AA, Ruckley CV. Audit of surgical audit. *Lancet* 1986;i:23–6.
- 3 Black NA. A regional computerised surgical audit project. *Qual Assur Health Care* 1990;2:263–70.
- 4 Chambers *Twentieth Century Dictionary*. Edinburgh: Constable, 1973.

AUTHOR'S REPLY

The comments by Iain Crombie and Huw Davies are a useful contribution to consideration of the use of large data sets. The definition that I chose was designed to draw some sort of boundary around what would otherwise have been an enormous topic that would have justified a book rather than a review article. The article was aimed at those who are attempting to use administrative data in audit and not the custodians of large data sets that are now routinely collected specifically for audit, on the assumption that the latter group will be aware of most of the issues raised and will have taken steps to overcome the problems that were identified. I agree that a better definition is needed, and Crombie and Davies illustrate the complexity involved in achieving one.

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Public health medicine and public health dentistry information resource

Many public health physicians are keen to improve the quality of their work through audit. However, their efforts are being restricted by the lack of dissemination of information about audit within the specialty.^{1,2} This had led to the situation in which many audit groups are working inefficiently because they are isolated, tackling the same problems and reinventing the same wheels.

In response to this a database of published and unpublished examples of audit in public health medicine and public health dentistry has been set up by the South East Thames Public Health Medicine Audit Project. Gathered over three years, the collection has been described as "one of the foremost collections" of public health audit information in Britain.³

The database is now being made available as a national resource in the hope that it will make a significant contribution to the dissemination of information and, as a result, to the development of audit within this challenging and important field.

Contributions to the database are very welcome, particularly accounts of public health audits, standards, proformas,

checklists, and so on. Requests for information and inquiries about the database should be addressed to me (or Kay Pennick).

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- 1 Bhopal RS, Thomson RG, White M, Watson A. Audit of public health medicine: the Northern region's approach. *J Public Health Med* 1993;15:255–62.
- 2 Jacobs RE. Help on the horizon. *Public Health Physician* 1993;4:11–12.
- 3 Richman A. *The Kent Public Health Medicine Audit Project – an evaluation*. Brighton: University of Brighton, 1992:8.

BOOK REVIEWS

Audit in Mental Health Services. Jenny Firth-Cozens (pp 83; £9.95). Hove: Laurence Erlbaum Associates, 1993. ISBN 0-86377-311-7.

Mental health is widely believed (not least from within) to be an area of almost insuperable difficulty for investigations such as clinical audit, which rely on measurement and standards. The perceived problems arise from three main assumptions: that it is uniquely difficult to quantify parameters of mental health, that there are particular problems of attribution to service interventions because of the uncertain but probably multifactorial causes of most mental illnesses, and that patients with mental illness cannot be relied on as a source of self report. The effect of these beliefs can be to inhibit audit altogether or to arrest it at the stage of case review and prevent any read across from experience in other areas of health. None of the underlying assumptions really stands up to examination. There is now a range of standardised psychological rating scales of demonstrated validity and reliability; multifactorial causation is the rule rather than the exception for all states of health and illness; and, on topics other than their purely personal preoccupations, the views of mentally ill people reassuringly resemble those of people with chronic physical disorders. Some areas of mental health, notably behavioural psychotherapy, already make extensive use of measurement and rating in routine practice. There are many similarities between mental disorders and conditions such as diabetes, cancer, or chronic physical pain which should allow mental health practitioners to share the audit methodology and experience of their colleagues in these areas.

The benefit of a text such as this may be as much in the implicit message of the title – that mental health services are appropriately included in the general