LETTERS

Resources for audit

Since 1991 and the development of government initiated consumerist trends in health care, the interest in audit activity among all health care professionals has risen sharply. This interest is evident through the growing volume of clinical audit activity and the emerging audit techniques which are now in place in many health care settings.

Although this emerging interest should be actively encouraged and endorsed at every level, the disparity and inequity of funding arrangements for audit activity require urgent attention if audit is to become a reality across the professions. In the first edition of *Networking Audit*¹ the editor noted that audit is now moving forward at a significant pace, thanks to the significant allocations made by the Department of Health to regions. However, the actual significance of this allocation needs to be carefully considered.

Until 1993, £110m has been allocated to medical audit. This money is protected and "top sliced." In comparison, no similarly secured allocation has been made to clinical audit but instead each region is expected to make appropriate bids for audit money. Even with this allocation of resources to medical audit, Marsh states that "it has been difficult to identify ways in which the audit has led to better or more efficient care."²

It seems unacceptable for this situation to continue while many of us are endeavouring to introduce quality audit activity systematically as a fundamental component of quality care without adequate resourcing. Perhaps this is a situation where decisions are being made about the value of certain health care outcomes.

Although some centres "allow" clinical audit activity to be resourced from medical audit funds, this perpetuates a hierarchical, status led approach, which is not conducive to collaborative working or in line with the principles of total quality management. If collaborative, multi-professional audit activity which focuses on the patient rather than the particular profession is to become a reality, then equity of resources must be a priority. Nursing and therapy professions are investing considerable time and effort in making audit a reality, they should be given the financial resources to make it effective.

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- 1 National Nursing and Therapy Audit Network. *Networking audit* No 1, Summer, 1992.
- 2 Marsh P. Clinical audit in the Oxford Region. *Auditorium* 1992;1:3.

Minimally invasive endometrial surgery

Several relatively new techniques have emerged in recent years to treat the endometrium directly when there are symptoms of dysfunctional uterine bleeding. These should reduce the number of hysterectomies performed.

Though initial studies suggested that the techniques are safe, with low mortality and morbidity, they were conducted by enthusiastic gynaecologists on small groups of women.^{1,2} A joint working party of the Royal College of Obstetricians and Gynaecologists and the Society of Gynaecological Endoscopists agreed on the urgent need for a prospective survey of these techniques. Those presently on offer include resection of the endometrium with a diathermy loop or destruction of the endometrium by laser or rollerball diathermy or by extremes of temperature (radiofrequency and cryoablation).

A national survey, which will start in 1993, has several aims. The frequency of use of the various techniques, the type and incidence of complications, and the effect of other features which may be associated with complications (particularly the experience and training of the operator) will be assessed. It is also intended to develop an acceptable standard for the level of training and experience necessary before such techniques may be undertaken unsupervised.³ Finally, laying the foundations for future studies of medium and long term complications is envisaged, which can be achieved by "flagging" appropriate cases on the NHS central register.

Pilot studies are currently in progress; they have three major objectives: to ensure the suitability of the data collection form; to open up lines of communication between the national coordinating team at the college's audit unit in Manchester and local coordinators, gynaecologists, secretaries, theatre managers, etc, in the pilot hospitals; and to ensure that gynaecologists are prepared to complete their own personal registration forms and to put their own personal identifying number on the individual patient forms.

Following these pilot studies data on operations for one year will be required from every hospital in the United Kingdom to give sufficient numbers to allow for worthwhile statistical analysis. Currently all units are being contacted and their participation is being requested. It is hoped that the numbers responding will exceed the 80% achieved in the last national gynaecological survey of laparoscopy published in 1978.

As a result of the survey it should be possible to define more clearly the complication rates found in routine practice with the new methods of treating dysfunctional uterine bleeding. The survey may also provide hard data to support the wider use of these techniques. A full and detailed analysis of these data will be published and will include mortality, complication rates, and suggested guidelines on the suitable

training required for performing these techniques safely and effectively.

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- 1 Gannon MJ, Holt EM, Fairbank J, Fitzgerald M, Milne MA, Crystal AM, et al. A randomised trial comparing endometrial resection and abdominal hysterectomy for the treatment of menorrhagia. *BMJ* 1991;303:1362-4.
- 2 Magos AL, Baumann R, Lockwood GM, Turnbull AC. Experience with the first 250 endometrial resections for menorrhagia. *Lancet* 1991;337:1074-8.
- 3 Macdonald R, Phiggs J, Singer A. Endometrial ablation: a safe procedure. *Gynaecological Endoscopy* 1992;1:7-9.

Clinical guidelines

In March general practice researchers, family health services authority (FHSA) managers, medical auditors, and health authority planners – all with some experience of developing or implementing guidelines – attended a seminar at the King's Fund Centre to consider the aims of management guidelines for primary care, how guidelines are implemented, and their effectiveness in influencing practice.

As quality is multidimensional introducing guidelines to improve care invariably entails trade offs or tensions between different dimensions – for example, between clinical freedom and public accountability; professional development (usually of medical practitioners) and service development (engaging all the professional groups comprising primary care services); and between the health care needs of individuals and populations.

Imposing protocols with penalties – whose prototypes exist in primary care in the targets for cervical screening and immunisation – were considered to be the worst outcome of developing guidelines and external guidelines attempting to specify "best" practice or minimum standards as unworkable because of uncertainty in many areas of clinical practice. Furthermore, trials of investigations and treatments may produce conflicting results and there may be a lack of consensus, such as in the management of hyperlipidaemia or for menopausal risk factors. Those formulating guidelines need to reflect these ambiguities without compromising utility.

Few robust studies of the implementation of clinical guidelines exist, particularly in primary care. In the general practice setting there is a long timescale of service and practice development. Primary care practitioners (doctors, nurses, and professions allied to medicine) are pivotal in improving preventive services and management of chronic disease, and in these contexts guidelines should be used as a tool for practice development. Implementing guidelines, even national guidelines, must

be a local collaborative activity. Academic departments of general practice can design or adapt guidelines in consultation with other academic or hospital departments and FHSAs and medical audit advisory groups. FHSAs need to be responsible for supporting practices to help practitioners cope with the increased time required for structured care. Purchasers and regional health authorities need to ensure funding for local initiatives, and departments of public health should set priorities for guidelines according to local epidemiological factors and health needs assessment.

To evaluate the effect of guidelines suitably large studies are required to detect changes in process and outcome measures. These studies should be restricted to answering questions about effectiveness; local projects on guidelines will need to be audited to ensure that their content and implementation fit local conditions. In addition, clinical care guidelines as part of service development require understanding of how change happens as well as being grounded in evidence that procedures are effective. This relies on action research and audit. A simple notion of guidelines as intrinsically virtuous and necessarily improving the quality of care is irresponsible.

The current enthusiasm for general practice guidelines and other clinical guidelines is not matched by a commitment to evaluating their effect on practice. Evaluation should have a high profile within the NHS research and development strategy, and it needs national and regional coordination.

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BOOK REVIEWS

Assessing the Quality of Health Care.
Richard P Wenzel, ed (pp 512; £58).
Baltimore: Williams and Wilkins, 1992.
ISBN 0-68308-924-2.

A glance at the newspapers or medical literature of any rich, technologically advanced Western country is enough to make it clear that its systems for the provision of health care are in a state of turmoil, if not chaos. The reasons are fairly clear, though the solution is not. After our successes in controlling the major infectious killers we have been much less effective at getting to the root cause of the diseases which have taken their place, notably ischaemic heart disease, stroke, cancer, diabetes, and the rest. We have made some inroads into their prevention and have become extremely effective at patching them up

with expensive high technology intervention. Because of, or despite these activities there is an unpredicted increase in the numbers of non-too healthy old people in our populations.

No Western system of health delivery seems to be able to cope with increasing costs of health care. In Great Britain the government's reaction has been to impose one reform after another on the NHS, each one demanding greater efficiency. The latest reform was designed to improve efficiency by trying to make a clear cut division between purchasers and providers. One of its major shortcomings was that, like so many of its predecessors, it failed to define its goals and objectives in a way which would allow them to be compared with previous approaches to the organisation of health care. In this sense it was a badly designed experiment. But one of the major problems in this field is that the scientific basis for trying to assess the quality of health care, which is what health provision is all about, is extremely primitive. It is essential, therefore, that progress is made in the important aspect of medical practice, so that in the future adequate pilot studies can be carried out before massive reorganisations of our health services are undertaken, without any clear evidence that they will work.

These messages have certainly not been lost on those who are trying to improve the quality of health care in the United States. For this reason the publication of this new book, edited by Richard Wenzel, is of great interest. He has amassed nearly fifty authors and has covered every aspect in considerable detail. The opening sections put the problems into historical perspective and then deal with the thorny question of how to define and measure the quality of health care. The historical chapters give an extremely balanced view of the problems of health care in the United States, but when we get to those which attempt to get to grips with the assessment of health and illness we run into a mound of frightening acronyms and jargon, some of which will be particularly heavy going for British readers. The book ends with a series of chapters which describe approaches to assessing quality in many different subspecialties of clinical practice.

Many of the chapters in this comprehensive book are extremely dense and heavy going. But, overall, it is a thorough and balanced review of the current state of the art in the extremely difficult area of assessing the quality of health care. Although it gives an American perspective, says nothing about systems in other parts of the world, and ignores the developing world completely, those who are involved in trying to assess the quality of health care, whatever their specialty, should try and persevere with it. It does not provide many answers, but it offers several interesting new approaches which should undoubtedly be explored within the British system.

Biological systems are extremely complex; sick people are certainly no exception. Alvin Feinstein pointed out recently that we do not yet have the

statistical methods for tackling many of the types of problems which we encounter when we try to assess outcome and the quality of clinical care. But we have to try, and those who are involved in outcomes research, medical audit, or in simply trying to improve the service to their patients in their role as providers should be grateful to Dr Wenzel; he has done us a great service by bringing together this group of authors and providing such a useful baseline on which we can develop our thoughts.

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Curing Health Care. New Strategies for Quality Improvement. Donald M Berwick, A Blanton Godfrey, Jane Roessner (pp 315; £22.50). Oxford and San Francisco: Jossey Bass, 1990. ISBN 1-55542-294-2.

Four years ago, when I started leading sessions for doctors on quality there were two common (mis)conceptions: that quality equated to the technical competence of the medical practitioner and that quality services could be achieved only with additional resources. The conclusion is obvious: doctors do a good job and with more money it would be better! Fortunately time has moved on: quality, avoided and marginalised in the mid-1980s is now everyone's business again, and some – the more adventurous – are welcoming the participation of patients and users in the quality debate.

Hospital managers too are, quite rightly, becoming more rigorous in their considerations of quality, and *Curing Health Care*, a report on the national demonstration project on quality improvement in health care, comes at a fortuitous moment. Its strength is in the sound understanding the authors have of the nature of organisations and the change process. It shows how Berwick's philosophy of continuous quality improvement or total quality management¹ should be applied.

The need for sound management, leadership, visions, values, clarity and purpose are emphasised by the authors. There is a reassuring understanding that blaming is counterproductive ("fix the system, not fix the blame"), that there is a need to work outside formal structures, and that we are dealing with complex problems with no "quick fix" solutions. Further, the book acts as a manual, telling stories of how things were achieved and contributing helpful methods: process flow diagrams, brainstorming and cause-effect diagrams, data collection forms, Pareto diagrams, histograms, scatter plots, and so on, which will help people to engage in the work constructively.

However, like all exciting things, I would counsel a little caution. For example, as the authors readily admit, none of the examples quoted impinge on medical practice and, though changing practice is often possible in pilot projects, achieving sustained organisational change is much more difficult.