Viewpoint

The audit process and medical organisation

Tim Packwood, Susan Kerrison, Martin Buxton

Both the NHS review working paper on medical audit¹ and the subsequent health circular² defined audit as a "systematic" process and referred to it respectively as "routine" and "regular." Early writings, exhortations, and guidance emphasised that medical audit was continuous and cyclical in nature.³⁻⁶ A systematic process that involves considerable numbers of staff, within a complex institutional setting such as a hospital, can hardly be achieved without formal and explicit organisational arrangements.

"The process of audit needs to be conducted within a clearly defined organisational framework, if it is to be fully effective".¹

An uncertain organisation

The working paper and the health circular were clear that audit was a matter for the medical profession to determine and, allowing for variety of local circumstances, placed accountability for overseeing audit with local audit committees.^{1,2} These had been envisaged as district based in the (1989) working paper but, with a clearer understanding of the implications of the division between purchasers and providers, became seen as unit based in the (1991) circular. But the authority of local committees was never defined, and their accountability appeared uncertainly divided between the hierarchy of the service and the profession. In their guidance to clinicians in setting up audit, for example, Ellis and Sensky saw unit audit committees reporting to a district audit committee that, itself, had responsibilities to both the region and the local medical advisory committee.⁷ At the specialty level the guidance from the professional bodies was that the unit audit committees should identify a lead clinician for audit for each specialty.^{5,8} Again, the authority and accountability for undertaking audit carried by such roles was undefined: they would perforce rely upon "leadership." So the working paper's prescription for a clearly defined organisational framework was hardly realised. Instead there was a rather hazy division between professional and hierarchical responsibilities which reflected the two pronged way in which audit has been introduced.

For the past 18 months we have been studying the implementation of medical audit

within general medicine in four acute hospital units, in a study commissioned by the King's Fund to evaluate aspects of the white paper's proposals. The hospitals were deliberately chosen to reflect contrasts in size (ranging from 900 beds in the largest to 400 in the smallest), in function (one was a teaching hospital, three were general hospitals), in status (two were NHS trusts and two were directly managed), in use of information technology (one had implemented resource management, the three others began to do so during the research period), and in clinical management structures (one had already implemented a clinical directorate structure, the three others moved towards this over the research period). The core groups of consultant staff in the specialty or subspecialty meetings observed ranged from two in one hospital to 23 in another. All four sites introduced audit support staff coincidentally within the research period.

The study involved several elements.

- Observation of 45 specialty or subspecialty audit meetings and 37 local audit committee meetings
- Interviews with 19 of the major participants (lead clinicians, consultants, and audit officers) and 25 others in roles assumed to have an interest in audit (general managers, quality assurance officers, nursing managers, information officers, and directors of public health) in the four sites
- Surveys of the time costs involved in presenting audit in the four specialty and subspecialty groups, the opinions of junior doctors in three of the four sites about the purposes and achievements of medical audit, and the work of audit support staff across the nation.

This research, in four different hospital settings, served to confirm speculation stimulated by previous research, teaching, reading, and discussion that the particular nature of medical organisation cannot help but constrain associated activities such as medical audit. In medical audit this occurs owing to inherent diversity in accountability and authority, nature of commitment, and relationship to the wider hospital environment of different types of hospital staff.

ACCOUNTABILITY AND AUTHORITY

Because most medical specialties are made up of two distinct types of staff – junior doctors

**Brunel University,
Uxbridge, Middlesex
UB8 3PH**

Tim Packwood, senior lecturer in public and social administration, department of government
Susan Kerrison, research fellow, Health Economics Research Group
Martin Buxton, professor and director, Health Economics Research Group

Correspondence to:
Dr Packwood

Accepted for publication
22 July 1992

Organisation of work among consultants and junior doctors

completing their professional education and training and consultants – medical audit has to operate in the context of two very different ways of organising work (figure),⁹ which have their own distinct properties and impose very different behavioural requirements.

Junior doctors are members of separate managerial hierarchies,¹⁰ accountable for their work to their consultants. The managerial relationship is particularly strong in medicine because it is bolstered by professional and educational forces. Junior staff wish to become fully qualified professionals like their consultants, whose organisational authority as managers is strengthened by their accepted professional status. To become so qualified the juniors are looking to their consultants to teach and train them and promote their careers, as well as to manage their work. A further factor strengthening the relationship is that the numbers involved in these managerial hierarchies are small. The juniors and their work are well known to their consultant managers, and accountability is clear and direct. Consultants can, and do, readily move in to direct the day to day work of their juniors as the occasion demands. Our surveys of the opinions of junior hospital doctors regarding the purposes of medical audit suggested that one of its main achievements was to make them more familiar with the expectations of their consultants. Junior staff were aware that their consultant managers required them to take part in audit, and this provided a compelling incentive for their participation.

Yet consultants are members of a different type of work group. Their accountability is not hierarchical, to a manager, or only partially so. It is rather diffused between their patients, their profession, and to their employing authority for satisfying the terms of their contracts and adhering to approved policies. They are members of a professional collegiate association, an association which at the local, operational level is relatively loosely knit. The power that members can exercise with reference to one another stems from their personal status within the medical profession, reflecting such factors as professional expertise, seniority, ability to convince others, and the shifting opportunities and circumstances that are encountered from day to day. It does not stem from their organisational authority as managers. For consultants the strongest incentive for participating in medical audit is that it provides an opportunity to think about, and perhaps improve, their professional practice.

So if medical audit is to impact on the junior staff it has to be consistent with the realities of

the managerial hierarchy, providing them with ways of proceeding that are accepted as good practice by their consultant managers. For the consultants medical audit has to be credible to individuals and convince them that it helps their professional work and will not harm their professional status. It may take the time and skills of sensitive professional leadership to agree a standard set of treatment procedures. But unless such agreement is achieved it is difficult to translate medical audit into clear managerial policies for the junior staff. The possibility of unit or district committees, or both, overseeing the development of audit may be felt by consultants to be introducing an element of hierarchical management that is unacceptable to members of an association. The position of the lead clinician for audit in the specialty, who is responsible for maintaining the process, may prove vexed for the same reason.

The dichotomy between the properties of hierarchies and associations is likely to complicate medical collaboration with other disciplines, which are almost inevitably hierarchically managed, and clinical audit activities or broader quality assurance initiatives.

NATURE OF COMMITMENT

Just as the participants in medical audit experience two different methods of organising work, so they present two different patterns of commitment. Junior doctors are temporary members of the local medical workforce, with a temporary commitment; the most junior doctors being the most temporary, requiring to move on to a different post within as short a time as three months. For all the reasons discussed above, the allegiance of junior staff to their consultant managers is likely to be strong for career purposes whereas allegiances to the continuing future of the specialty or to the hospital are inevitably weaker. The consultant members by contrast, have a dual, sometimes conflicting, interest in the future of both their professional specialty and the hospital where they work.

So there are practical problems in organising audit that satisfies the requirements of both groups. If junior doctors are to experience an audit cycle it has to be undertaken fairly quickly, so that those present at the beginning are also present to see change implemented and its effects reviewed. Topics for audit need to be geared to the restricted experience of the junior staff and to their educational needs. The views of their consultant managers of the relevance and value of any audit topic are likely to influence the attention given to it by the junior staff. The consultants are in danger of becoming bored and disillusioned with audit if the same topics are repeated every half year and if the subjects selected are at too basic a level. Topics for audit need to be geared to the specialist experience, interest, and responsibilities of the consultants. And because the professional associations in which the consultants work operate on the basis of reaching agreement,

consultants are likely to be very wary of any audit that might provoke explicit criticism of one of their number. There may be nothing to be gained, and a lot to be lost, from making enemies.

RELATIONSHIP TO THE WIDER HOSPITAL ENVIRONMENT

The analysis in both the preceding sections suggests that if any significant action is to result from medical audit it is as a result of agreement by the consultants. They can decide as an association, for example, to introduce a new set of requirements for handling blood transfusions and, providing they have sufficient energy and conviction, they can then, as managers, direct their juniors to adopt the new procedures and monitor their adherence to them. But some matters that arise in audit are outside the scope of the consultants' authority, either as managers of junior staff or as members of an association. Some issues have to be referred out to the wider system, perhaps requiring an agreement with other disciplines or reference to unit general managers.¹¹

Traditionally, reference to the wider system has depended on the ad hoc efforts of any or all of the following: individual consultants, the medical representative machinery, or proactive general managers. How, or by whom, it should be undertaken as part of a systematic audit process seems uncertain. It is our experience that at the specialty group level medical audit is medically monopolised and there is some reluctance to draw in members of other disciplines. This obviously reduces the possibility of advancing some of the wider implications exposed by audits as they occur. The presence of a pharmacist at a meeting, for example, could be useful in deciding whether or not to consider seriously changing prescribing patterns.

The guidance on implementing medical audit suggested that the local audit committees should serve as a channel between the medical specialties and other interests. And the channel was potentially two way, concerns of the doctors being passed to other disciplines and interests while those of the latter could be passed down to the specialty audit groups. We have certainly found evidence of these committees relating medical

audit to a wide number of different interests in a hospital or across a district, but their authority in doing so is often unclear. Of the five local audit committees we studied, only two had regular representation on behalf of general management; however officers responsible for information systems and resource management did regularly attend a third committee.

A different solution would be to place the first line of responsibility for taking up issues that arise in specialty audit with the lead clinician. Indeed, in our experience many do accept this as a somewhat demanding and unlooked for part of the job. Unresolved or contested issues could then be referred to the local audit committee. However, allocating any form of "managerial" accountability for action to roles occupying leadership positions in this way runs counter to the nature of medical organisation discussed earlier.

Living with the organisation

The organisational difficulties for medical audit outlined above cannot be readily solved. The mandatory systematic process of medical audit is a new addition to clinical activity and has to operate within the parameters of an organisation that has evolved to meet other needs – namely, controlling work; ensuring appropriate standards; providing education and training; and, of course, personal and professional self interest. But there are approaches, many of them now becoming accepted practice in the health service, although not all directly concerned with audit, which have the effect of strengthening medical audit (table).

SUPPORT FOR AUDIT

The development of medical audit has been accompanied by the emergence of a new health service discipline – that is, audit support staff who are responsible for facilitating the process.¹² Senior grades of such staff may be medically qualified but most are not. An audit office can remove some of the pressure from the clinicians in keeping audit running – for example, audit staff can help in collecting and interpreting data, in keeping abreast of published work in audit, in recording decisions reached in audit meetings, and they may be able to help in negotiating the

Approaches to improving medical audit

Approaches	Problems			Implementation
	Authority and accountability	Commitment	Relationship to the wider environment	
Support for audit		✓	✓	Already available
Increasing collective responsibility	✓	✓	✓	Already available
Managerial interest		✓	✓	Likely – as organisation of the NHS stabilises
Different levels of audit	✓	✓		Likely – implicitly moving in this direction
Strengthening the educational impact of audit		✓		Requires change in professional organisation
Clinical audit			✓	Requires change in professional attitudes
Coordination by contract	✓	✓	✓	Possible – as internal market becomes stronger

wider implications of audit with other disciplines and interests. The coordinator or facilitator heading the audit office is generally hierarchically accountable to the clinician chairing the local audit committee. The role of the office is likely to be seen in different ways according to local priorities. In some cases it may have a key task, such as developing information technology. It may be seen as a central resource for the audit committee or it may be effectively divided and its staff devolved to work with the specialty groups across the hospital. Whatever the precise arrangements, the presence of support has the potential to facilitate medical participation in audit.

INCREASING COLLECTIVE RESPONSIBILITY

We suggested above that consultants (and their firms) function in the hospital setting as individual units within a loose professional association. Gaining the collective agreement that is necessary to implement audit takes effort and time. But collective working is being strengthened by the creation of subunit organisation in hospital.^{13 14} Clinical directorates or departments are organised around delivering a common service product – for example, surgical treatment or gynaecology – and they develop a collective approach to their work that embraces the constituent consultant firms and other disciplines. If resources are allocated to the subunit or directorate to manage and some local discretion is possible in the way that priorities are determined and resources applied so that there is a greater incentive for cooperative working,¹⁵ audit, which is concerned with the quality and efficiency of work, will be seen as a helpful and crucial activity.

MANAGERIAL INTEREST

The initial guidance on medical audit emphasised that general managers had an interest in audit; that they would be informed of its results; and that they could, if they felt it necessary, initiate particular audit topics. But there have been many other calls upon managerial interest as the white paper's proposals have been implemented. Given a period of stability, managers may indeed turn their attention towards audit. Clinicians are not wholly enthusiastic. Many of our respondents worried that audit could be an instrument of control as well as of education. But managerial involvement does provide for the wider implications of audit to be considered. Managerial interest, whether by general managers or clinical directors, may also serve to increase medical commitment to engage in audit. If managers show that audit is being taken seriously, and that it can lead to questioning and change of policies and resource allocation, participation by doctors will be seen as having some point.

DIFFERENT LEVELS OF AUDIT

The differences in the way that the work of junior doctors and consultants is organised, coupled with the differences in education,

professional experience, and commitment, suggest that regularly providing audit topics that satisfy both parties is difficult. Although both may benefit from the opportunity for reflecting on their practice, which is seen as the hallmark of the professional,^{16 17} the experience that provides the basis for reflection is very different between the two. If this is recognised one obvious solution is to construct an audit programme that contains attractions for both junior doctors and consultants.

Topics chosen for junior doctors would be appropriate to their experience and tied in with the postgraduate education programme; topics chosen for consultants would match their specialist interests and draw in experts in the same field from elsewhere. A variant would be to treat specialty audit meetings within the hospital explicitly as educative events for junior doctors, who make up most of the audience, and structure the programme accordingly. This has some similarities with the original guidance on setting up audit from the Royal College of Surgeons.⁸ It could be seen as part of a process, starting in medical school, to give doctors the necessary skills to undertake audit. Audit for consultant staff would be an external activity, conducted through the specialty groups that have been developed regionally and by the royal colleges. However, maintaining some connection between the two forms of audit seems important. As thinking and possibly treatment guidelines were developed at the suprahospital level, they would need to be converted into local guidelines through review with junior staff in the hospital based audit groups.

STRENGTHENING THE EDUCATIONAL IMPACT OF AUDIT

Although participation in audit is now compulsory for all hospital doctors, the commitment of junior staff to that participation might be strengthened if audit were seen as a more definitive component in the educational process – for example, if brief details of audits attended were entered in a training experience profile, together with notification if the individuals concerned had played any part in gathering data, presenting the audit, or implementing its results. Indeed if medical audit were to be linked more explicitly with postgraduate education it might be possible to specify several audit topics that staff were expected to experience at different service levels. Participation in audit would then be strengthened as it became instrumental to a professional career. But strengthening the educational aspects of audit would not be easy. The organisation of postgraduate medical education itself seems variable and inconsistent and similar to audit in its dependency on the commitment and enthusiasm of individual consultants.¹⁸

CLINICAL AUDIT

Early guidance on introducing medical audit certainly envisaged the possibility of multidisciplinary audits. Our evidence

suggests that it is still rare for doctors and professionals from other disciplines to come together in meetings that are clinically, as opposed to medically, focused. But by bringing together, for example, medical and nursing analyses of aspects of patient care a more informed view of the implications of changing treatment procedures could be gained. This again would require thoughtful audit programming that could provide a mix of unidisciplinary and multidisciplinary meetings.

COORDINATION BY CONTRACT

Potentially, this approach offers the most far reaching effects on audit. Earlier we argued that medical audit encountered difficulties because it had to encompass two different ways of organising activity: the hierarchy and the association. The development of the internal market, with the division between purchasing and providing activities, employs a third form of organisation – namely, the market. A scenario may be imagined whereby purchasers set out their requirements for audit in contracts with provider hospitals, not merely that audit takes place but specifying some of the issues that should be reviewed and their right to be notified of the results and of any resultant change in practice. The fact of reporting to the purchaser would strengthen audit as a form of accountability, increase commitment, and strengthen the incentive to negotiate results with other parts of the local hospital environment. Contractual specification by purchasers would then presumably determine the nature of medical audit, representing a significant shift away from the principles of professional and provider control that initially shaped its organisation.

Conclusion

The approaches outlined above are not part of a coherent package nor are they put forward as choices. They all, to a greater or lesser extent, address one or more of what had earlier been defined as organisational problems facing audit in hospitals. These problems stemmed from audit having to function within the context of two totally different ways of organising medical activity, from the existence of different patterns of staff commitment to their work and their hospital, and from the necessity for negotiating the implications of audit beyond the medical group. The table also indicates an assessment of the likelihood of improvements being achieved. Some, such as the presence of audit support and increasing collective responsibility, are already available. Others, such as different levels of audit, managerial interest, and, possibly and most significantly, coordination by contract, seem to be impending. And some, such as greater educational visibility and clinical audit, seem unlikely without change in medical beliefs and organisation.

In presenting these approaches, the argument has assumed that medical organisation is unlikely to change fundamentally, at least in the near future. So where alteration is required it must be alteration in the organisation of medical audit. This means recognising that medical audit must become more flexible: its value is reduced if it is always segregated and never integrated with the wider service management or with the activities of other disciplines. The development of the clinical directorate or its equivalent as a setting in which all the constituent service providers manage and review their activities¹⁹ offers medical audit a local organisational focus that encourages integration and flexibility. That said, clinical directorates, certainly represent “contested territory” between managerial and associational forms of organisation.²⁰

But a second, familiar message is that scope for improving medical audit from less dramatic organisational interventions is considerable. Spending the time to create a programme that responds to the different interests and abilities inherent in any audit group or arranging audit meetings at times to suit many disciplines are targets that should be achievable within the existing framework.

- 1 Secretaries of States for Health, Wales, Northern Ireland, and Scotland. *Medical audit working paper 6*. London: HMSO, 1989.
- 2 Department of Health. *Medical audit in the hospital and community health services*. London: DOH, 1991. (HC(91)2.)
- 3 Shaw CD. Aspects of audit. The background. *BMJ* 1980;280:1256–8.
- 4 Frater A, Spiby J. *Measured progress: audit for physicians*. London: Public Health Directorate, North West Thames Regional Health Authority, 1990.
- 5 Royal College of Physicians. *Medical audit – first report*. London: RCP, 1989.
- 6 Standing Committee on Postgraduate Medical Education. *Medical audit – the educational implications*. SCOPME, 1989.
- 7 Ellis B, Sensky T. A clinicians' guide to setting up audit. *BMJ* 1991;302:704–7.
- 8 Royal College of Surgeons. *Guidelines to clinical audit in surgical practice*. London: Royal College of Surgeons of England, 1989.
- 9 Thompson G, Frances J, Levacic R, Mitchell J. *Markets, hierarchies and networks*. London: Sage, 1991.
- 10 Rowbottom R. *Hospital organisation*. Oxford: Heinemann, 1973.
- 11 Edwards B. Controlling Doctors. In: Pollit C, Harrison S, eds. *Handbook of public services management*. Oxford: Blackwell, 1992:107–17.
- 12 Firth-Cozens J, Venning P. Audit officers: what are they up to? *BMJ* 1991;303:631–2.
- 13 Packwood T, Keen J, Buxton M. *Hospitals in transition*. Milton Keynes: Open University Press, 1991.
- 14 Central Consultants and Specialists Committee. *Guidance on clinical directorates*. London: BMA, 1990.
- 15 West P. *Understanding the NHS*. London: King Edward's Hospital Fund for London, 1988.
- 16 Schön D. *The reflective practitioner: how professionals think in action*. London: Temple Smith, 1983.
- 17 Batstone GF. Educational aspects of medical audit. *BMJ* 1990;301:326–8.
- 18 Dowling S, Barrett S. *Doctors in the making*. Bristol: School of Advanced Urban Studies, University of Bristol, 1991.
- 19 Packwood T, Keen J, Buxton M. Process and structure. Resource management and the development of sub-unit organisational structure. *Health Services Management Research* 1992;5:66–76.
- 20 Disken S, Dixon M, Halpern S, Shocket G. *Models of clinical management*. London: Institute for Health Services Management, 1990.