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.

BRENDAN MCCORMACK
Institute of Nursing,
Radcliffe Infirmary,
Woodstock Road,
Oxford OX2 6HE

- 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.

CHRIS OVERTON

MIKE MARESH

Royal College of Obstetricians and Gynaecologists
Audit Unit,
St Mary's Hospital,
Manchester M13 0JH

- 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