Psychiatric Bulletin (1992), **16**, 762–763

Role of regional audit facilitators in psychiatry

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At most conferences on medical audit we are reminded that medical audit is centuries old. What is new is the push for medical audit as a formal activity in which each clinician must take part. This push came from Mrs Thatcher's NHS review in 1989, invoking the spirit of market forces in the NHS. Whether this spirit is that of a goddess or demon, it is perhaps too early to know. As many of the Royal Colleges (Hoffenberg, 1989; Royal College of Psychiatrists, 1989; Royal College of Surgeons of England, 1989) and the Standing Committee on Postgraduate Medical Education (1989) produced their guidelines, the push to make medical audit a formal activity in which each doctor should take part became reality in 1989.

The Department of Health allocated £24 million for 1990/91, and medical audit became a part of the contractual agreement for clinicians from 1 April 1991. For 1991/92, the Department of Health allocated £41 million and for 1992/93 £42.1 million. Recently two journals have also been launched in this area: *Quality in Health Care*, published by the BMJ Publishing Group and *Auditorium*, published by the Postgraduate Medical Education and Training, Oxford University and Region.

In the Oxford Region, the Regional Audit Executive Group includes the chairmen of all the district audit committees and several regional officers, of whom three have been regional audit facilitators: one for surgical specialities, one for medical specialties, and one for psychiatry and community services. The regional audit facilitator in psychiatry and community services also convenes a regional psychiatric audit group, with representatives from each district and also from region-wide subspecialties. In principle, therefore, in each district there is a lead clinician in psychiatry who leads the organisation of medical audit activities in psychiatry and acts as representative on the district audit committee and on the Regional Psychiatric Audit Group.

The main role of the regional audit facilitator is to facilitate the sharing of information and ideas in order to inspire and encourage local and regional audit in psychiatry through the Regional Psychiatric Audit Group. Regular newsletters highlight various audit activities and developments within the region. The facilitator is also available to advise on audit projects and assist the Regional Audit Executive Group in deciding the funding of regional audit bids. The organisation of training and a survey of attitudes have also been undertaken.

Will all the doctors do medical audit simply because they are obliged to? There may still be many doctors who feel that audit is a waste of time, thinking that they already know why the standard of care is poor and how it can be improved. If a fraction of the £107 million ring-fenced money spent in medical audit in three years was spent on actual clinical services, it could have made a real difference to the standard of care, while audit may only find out what is already known.

There may be some other doctors who believe that quality is a commodity that cannot really be measured, or that we shall measure not the essence of quality but only what is easy to measure.

Some doctors may even think that medical audit can be damaging. It could raise expectations, stir up disappointments and produce a culture of blame. Having rights but not enough resources to provide good enough services is a cruel joke. Audit can help produce protocols, guidelines and manuals, and their bureaucratic implementations can produce a sense of protection against various eventualities and defend against anxieties. However, blind adherence to protocols can also be dangerous.

Some other doctors may feel that medical audit is a very good thing to do but that they themselves do not have time to do it. The pressures of clinical demands are such that any non-clinical activity appears unethical, though these have risen exponentially in recent years. It is not too difficult to find reasons for not doing medical audit and the findings of our regional survey, when available, will be most interesting.

Many doctors are truly interested in audit and are actively involved in it. As there is a hierarchy of needs, different people are motivated by different things. As it is difficult and time-consuming for a trainee to conduct research and publish it, medical audit and any publications arising from it can easily add to the weight of a CV. For consultants, too, medical audit can become a meritorious thing to do (for merit awards) and may become an important aspect of performance-related pay.

All the Royal Colleges are determined to use medical audit as one of the most important criteria for approving training schemes and trainers. In fact the

https://doi.org/10.1192/pb.16.12.762 Published online by Cambridge University Press

Royal College of Obstetricians and Gynaecologists has already approached district medical audit co-ordinators to find out about these practices. When the funding for medical audit is no longer ring-fenced and is included in the contracting mechanism, medical audit will be driven by general quality issues and business plans. Medical audit can also serve as an important tool in managerial processes, e.g. individual performance reviews, professional competence, quality management and hospital accreditation.

Whether audit will be used or abused would mainly depend upon the organisational culture. Hawkins & Shohet (1989) described five types of organisational cultures:

1. *Personal pathology culture*, in which problems are seen to arise from certain individuals (like rotten apples) who, if changed, cured, marginalised or removed, will improve the functioning of the department or the organisation. One can see medical audit serving as a powerful tool in such a culture.
2. *Bureaucratic culture*, where there are a huge number of policies, protocols, guidelines and memos covering all eventualities, mainly as a defence against anxiety. Medical audit can greatly facilitate this process.
3. *Watch-your-back culture*, arising out of conflicting goals, value systems, internal power struggles, rivalries and competitiveness which may be further fuelled by the spirit of market forces. Here, again, medical audit can serve a very useful function.
4. *Reactive/crisis culture*, where there is no time to reflect properly on the work or to plan ahead because people are just busy responding to the latest crisis. Medical audit can point at the areas where it may be useful to be proactive.
5. *The learning or developmental culture*, where learning becomes an important value in its own right and time is taken to reflect on effectiveness, learning and development.

I am sure many of us are interested in influencing our organisational cultures and in making them more true to the learning or developmental type. Medical audit activities can serve as the most valuable tools to this end.

References

HAWKINS, P. & SHOHET, R. (1989) *Supervision in the Helping Professions*. Milton Keynes: Open University Press.

HOFFENBERG, R. (1989) *Medical Audit: a first report, what, why and how?* The Royal College of Physicians of London.

ROYAL COLLEGE OF PSYCHIATRISTS (1989) Preliminary report on medical audit. *Psychiatric Bulletin*, **13**, 577–580.

ROYAL COLLEGE OF SURGEONS OF ENGLAND (1989) *Guidelines to Clinical Audit in Surgical Practice*. London: Royal College of Surgeons of England.

STANDING COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION (1989) *Medical Audit: the educational implications*. London: SCOMPE.

"The members of the Association dined together in the evening at the Freemasons' Tavern, when they were joined by several distinguished visitors. The usual loyal toasts having been duly honoured, the President, Dr Hack Tuke, proposed the health of 'The Bench and the Bar'. The health of the Commissioners in Lunacy and the Lord Chancellor's Visitors, was proposed by Dr Savage, and responded to by Drs Williams and Crichton Browne. The remaining toasts were, 'The President', proposed by Dr Bucknill; 'The Prosperity of the Association', by the President; 'The Ex-President', 'The President-Elect', 'The Council and Officers'". (Report of Annual Dinner, 1881).

"To actually merge themselves in the section of that Association might or might not be ultimately advantageous to this Society".

"He trusted they would never be so wanting in self-respect as to allow themselves to be merged into the British Medical or any other Association". (Conflicting views in the future of the MPA from the President, W. Orange of Broadmoor and Dr D. Hack Tuke, 1883).

"Old members years ago used to say that in provincial centres the meetings became slower, and the vitality of the Association suffered". (Dr T. Clouston of Edinburgh discussing venues for future Annual Meetings, 1886).

https://doi.org/10.1192/pb.16.12.762 Published online by Cambridge University Press