The College and Medical Audit

By KENNETH RAWNSLEY, Welsh National School of Medicine, Cardiff

Scarcely an issue of the more popular medical magazines appears nowadays without some reference to medical audit. A fair quantity of adrenaline flowed at a recent BMA Annual Meeting when doctors voted to have no truck with 'any imposed method of medical audit.' In the USA, however, the Professional Standards Review Organizations (PSROs)—over 200 in number—were created in 1974 by legal instrument and are mandated by Congress to carry out quality review of medical work in hospitals. Whenever audit is discussed, someone usually makes an ominous comment about the need for the profession to take steps before others take them.

The quality of medical care depends to a degree on the quality of its practitioners, and hence the assessment element in medical education is closely linked with medical audit. A large number of organizations in Britain are currently involved in monitoring professional standards of training or care, e.g. the General Medical Council; the managers of the National Health Service; the Health Advisory Service; the Mental Welfare Commission for Scotland; the Ombudsman; the DHSS Confidential Inquiry into Maternal Deaths; the Inquiry into Anaesthetic Deaths by the Association of Anaesthetists of Great Britain.

In recent years a plethora of 'disaster inquiries' has highlighted serious deficiencies in resources, management, clinical policies and skill in hospitals for the mentally sick or handicapped.

Since its inception in 1971, and following the inauguration of the MRCPsych., the College has become heavily involved in monitoring standards of training through the Approval Exercise and, with the Association of University Teachers of Psychiatry, through the Joint Committee on Higher Psychiatric Training. Visits to hospitals for scrutiny of training programmes inevitably require notice to be taken of standards of clinical care, and of available clinical resources.

Another facet of College activity which has indirect links with audit is the work of the College Committee on Sick Doctors. This was set up in the wake of the first Merrison Report, when it was hoped that the new Health Committee of the GMC would stimulate earlier declaration of incompetence to practise through illness. The College Committee explored ways in which the considerable resources of the College could be mobilized to support and help failing colleagues who might be willing, perhaps under some pressure, to seek expert help outside their own home territory. A pilot scheme launched in concert with the Association of Anaesthetists appears to be working satisfactorily. A detailed audit is not possible, however, because of the in-built secrecy which pervades the scheme.

More recently the College has addressed itself directly to the matter of audit by setting up a Special Committee on Medical Audit and also a Committee on Continuing Medical Education. The very act of establishing an audit committee raises the question of the extent to which a Royal College should allow itself to become executive in the matter of detailed monitoring of practice within its discipline. The College exists in order to promote and foster high standards of practice, but should this laudable aim find expression in using the College as an auditing agent? Certainly the inspection of posts and training programmes and the presence of a College Assessor on Advisory Appointments Committees may be construed as auditing activity of sorts. Should a College go further than this?

One concrete proposal generated by the Committee on Medical Audit is a study of suicides occurring in psychiatric hospitals or units or possibly committed by patients recently discharged. Most experienced psychiatrists have lost patients this way and may have been prompted to question themselves about possible clinical misjudgement or perhaps a breakdown of communication or lack of vigilance on the part of nursing staff. Occasionally a crop of suicides occurs in the same institution (there was a recent inquiry into such a circumstance) and again the question must be put whether this reflects some widespread malaise within the body politic of the hospital which warrants scrutiny. In short, a clearly defined and dramatic 'outcome' might serve as a point of departure for an auditing exercise which, one hopes, would be informed by a very constructive spirit and would not be in any sense a punitive or blame-laying activity. The Research Committee of the College is looking at this idea from the point of view of feasibility and method, and it might well result in proposals for at least a pilot study into hospital suicides.

The College is currently mounting a national inquiry into the use and practice of electro-convulsive therapy, under the direction of Dr John Pippard, and this too may be construed as an audit into resources, utilization and techniques.

Much of the work which has been carried out under the banner of medical audit, especially in the USA, has been in the fields of acute medicine, surgery, gynaecology and paediatrics. Elaborate schemes have been devised for monitoring medical care. A detailed analysis is made of the 'desirable' elements in the investigation and management of specific conditions. These desiderata may be based on the judgement of panels of experts, and the resulting protocols are used as standards by which actual practice in particular cases may be appraised.

I can envisage many difficulties in applying to psychiatry this elaborate approach to audit. Problems would arise in the

specification of disorders and also in obtaining a consensus on the optimum array of factors constituting the management process for defined conditions. Variations in ideology; the widespread use of multidisciplinary team approaches to diagnosis and treatment; the need to assess both clinical and social 'outcomes' of treatment: all these would complicate audit in psychiatry.

However, at a less sophisticated level much could be done to heighten self-scrutiny and to promote constructive feedback. The case conference may be an admirable forum for audit. A cogwheel division may decide to take a hard look at patient turnover in different firms; at out-patient waiting lists; at the use of Section 29 of the Mental Health Act; at prescribing costs in hospital.

The medical profession in Britain is ambivalent in its attitude to audit. There are fears that imposition of elaborate auditing procedures would be divisive, anxiety-provoking and productive only of a new bureaucratic apparatus. Nevertheless, audit of a kind is already extant, and the College has been involved since it was founded. Discussion and debate among members will no doubt take place in a variety of settings, and gradually the future role of the College in this large area will be fashioned.

Parliamentary News

(March to August, 1980)

The Mental Health Services

Figures were given on 25 March and 31 March for the numbers of consultants in the various specialties. For England and Wales the numbers are: Mental illness 1,055; Child and adolescent psychiatry 271; Mental handicap 149; for Scotland; Psychiatry 181; Child psychiatry 29; Forensic psychiatry 5; Mental deficiency 14.

The number of in-patients in psychiatric hospitals for mental illness in England and Wales has dropped from 143,000 in 1954 to 78,000 at the end of 1978. Of the 175,000 'or so' people admitted each year, only about 9,000 remain for over a year.

Figures were given on 23 May for the number of admissions to all psychiatric hospitals in England under the various compulsory procedure sections of the Mental Health Act. Admissions under Section 25 dropped from 6,713 in 1976 to 6,137 in 1978, and under Section 29 from 11,057 in 1976 to 8,299. On the other hand, Section 26 admissions rose from 756 to 962. It is not clear whether these last figures refer only to initial admissions under Section 26 or include those detained under Section 26 after having originally been admitted under Sections 25 or 29.

Asked about procedure for the investigation of complaints in mental hospitals, Mr Jenkin (2 July) replied that the findings of the Brookwood Inquiry did not suggest inadequacy in the present arrangements. Staff who felt concerned about aspects of patient care should know of the avenues open to them and be assured of management support.

On 3 July Dr Vaughan announced that the proposal to close the Henderson Hospital had been rejected and the hospital would be kept open and funded for the time being from 'secure units' allocations.

On 1 May particulars were given of local authorities which had reached the Guideline figure for residential and day care for the mentally ill. Thirty-two authorities were on target for residential provision, but only three for day care. On the other hand six authorities provided no residential accommodation, and there was a long list of others that had not yet provided day care. However, taken overall, it appears (15 May) that the level of 0.12 places per 1,000 population precisely matches the projection in 'The Way Forward'.

Treatment

In replying to a question on the use of psychosurgery on 5 June, Sir George Young said that in regard to detained patients the DHSS's view was that the Mental Health Act gave implicit authority to administer recognized forms of treatment for mental disorder without the patients consent where necessary, but that it was good practice to explain and seek consent from patients and agreement from relatives. Sixty-six psychosurgery operations were reported during 1979.

A similar reply was given on 1 May to Mr Stevens who was advocating a ban on the use of ECT. In both these replies when referring to the position of non-detained patients, the expression used was 'informal (voluntary) patients'. This equating of the present 'informal' with the former 'voluntary' patient appears to diverge widely from the original principles of the Mental Health Act according to which 'non-volitional' patients were to be admitted informally.

Questions were asked on two dates about the instruction of general practitioners in psychiatry and particularly in the correct use of psychotropic drugs, and it was alleged that in some cases a 'Big Mix' of antidepressants, anxiolytics and beta-blockers had caused deaths.

In the last weeks of the session a number of questions related to the loan by the Director of Public Prosecutions of pornographic material for the use of psychiatric hospitals in the assessment and treatment of certain patients. The