Forum

Audit in family practice

— S Furman
— J Smith

Note: This contribution, received from Drs Furman and Smith, from Cape Town, is placed in our Forum section to stimulate discussion. We will welcome some correspondence on the issue.

At a recent meeting in Cape Town, Dr John Smith said: "The essence of good medical care must be to provide a good service to our patients: this must incorporate reviewing and assessing what we do and how we do it. It must incorporate our duty to our profession to maintain appropriate standards of professional conduct and responsibility."

Accepting such inescapable requirements, which have been part and parcel of our professional life since the establishment of our Medical and Dental Council, it is but a small step to accept medical audit as an extension of continuing medical learning.

Introduction

Audit aims to define "norms" upon which medical practice is based. Once "norms" have been evolved it will be easy to review the abnormally good from which we can all learn, as well as the abnormally bad which must be evaluated and corrective action taken. The more feed-back a doctor can get about working methods and outcome, the greater their knowledge will be.

Audit has relevance to family practice, as family practice is that branch of medicine where over 90% of the medical action takes place each day and where 90% of the problems can be resolved simply, effectively and inexpensively if there are adequately trained health professionals available. The pivot of the health care system must be family practice/primary care. That means a service which meets the common health care needs of people close to their place of residence and work.

Hospitals and specialist services are expensive and often highly technical, consequently it is important that they are appropriately and properly used by the referral of patients for relevant reasons and that through 'shared care' of patients with other health professionals the traditional concept of personal, continuing preventive and holistic care can be given as opposed to perfunctory, fragmented and episodic care, which is often costly to the individual, the family, the community and to the State.

Much of the work can be delegated to other members of the health team, including the patient, the family and community. On the other hand for such a service to be effective, it will always need a well trained family practitioner to make diagnostic sense of the confusing array of signs and symptoms that make up much of this work.

Unless there is this sound primary level of health care, the rest of the system will be wasted, expensive and inefficient, no matter how skilled or how expert or highly specialised it is.

Thus we must show by documentation that what we are doing, we are doing *effectively* and *efficiently*.

Types of assessment audit

Assessment is always controversial! The very subject arouses strong feelings and all the particular applications of it invariably stimulate debate and discussion.

Assessment is an integral part of the education process. Without assessment, education is incomplete. Assessment in higher medical education can be classified as follows:

- Assessment done for the benefit of the learner (formative assessment; feed-back assessment)
- Assessment done for the benefit of the teacher (to help trainers and organisation know about their teaching)
- Assessment done for the benefit of a third party, eg. the State (to protect patients), the medical profession (to promote higher standards), university (to monitor a department), or for research.

Confusion between these three types of assessment leads to tension.

While most of this discussion is about assessment for the benefit of the learner, brief mention should be made of external audit.

If we wish to shape our own destinies, then it is important that we are knowledgeable of some national, regional and local annual statistics such as birth rates, perinatal, neonatal and infant mortality and morbidity rates.

The simplest form of audit

It is a truism, that we should 'learn from our mistakes', but how can we do it with the minimum of time and effort? Very simply by maintaining our own personal "black book" in which we enter a patient's name, date and brief facts of the case. Then periodically either personally, or in a small group, study and review these problem cases.

While statistics may suggest that all is not well,

they do not tell us what to do. By keeping a record of problem cases and asking "Why did it happen?" and carry out an intensive review, performance of clinical care can often be dramatically improved.

Basic audits

The first audit one should undertake should be a *workload audit* to define the spectrum of diseases seen. Once a workload audit is defined, one knows the content of one's continuing medical education.

The second audit which should be carried out is a *role audit* to see who in the health team should be doing what and that includes the patient. These audit meetings should, on occasions, include members of the community health team and voluntary organisations. Only in this manner can we talk about providing comprehensive care.

The third audit which should be carried out, is an *audit of one's records*. Even though good records may not be essential for good medical care, it will be agreed that good care must not only be given, but must be seen to be given. Unfortunately there is much evidence that very few records have developed beyond the stage of an aide-memoire. A useful factor to include in any such audit, is legibility. Most audits on this theme show 40% of notes are illegible. Consequently graphic and check list systems have much to recommend them. Good and legible medical records are essential in any group practice.

We all wish to improve the quality of care – that is the best care in the shortest time at the most reasonable cost. Incorporation of these basic audits will help us attain these objectives based on solid scientific evidence.

There are two other systems of evaluation which stand out, that we would consider.

- An age/sex register
- A disease register

Dr Les Smith, chairman of the subcommittee of Practice Management of the Cape Western Branch, dealt with these.

"The practice of good family health care requires

access to reliable data on population served, particularly with regard to preventive and promotive health and the long term management of chronic illness."

The Age/Sex Register and Disease/Diagnostic Register are analytical tools developed by the Royal College of General Practitioners. The Age/Sex Register is a list of patients of each sex arranged in birth date order and alphabetically within each year.

The Disease/Diagnostic register is a list of patients with particular problems (often long term conditions) which the practitioner wants to follow closely, such as diabetes, hypertensive and asthmatic patients.

The advantages of these registers are:

- age/sex profile of a practice
- it identifies 'at risk' groups for preventive measures
- it provides clinical material for practice based research, evaluation and teaching. He presented an age/sex register he set up in the Hout Bay area.

The aim is to provide quality of care by moving away from episodic curative care towards comprehensive and continuing care with access to reliable data for medical audit.

Other useful audits

Dr Alison Hutcheson, a general practitioner in Fish Hoek, performed an audit on 100 consecutive *patients referred* to consultants.

She excluded telephonic advice, radiological referrals and patients referred to hospitals/clinics for financial reasons.

She noted the reasons for referral, what she required from the specialist and whether she referred on the first or subsequent visits.

Her referral rate was 9%.

This was a useful audit in that the exercise itself highlighted the importance of making it clear in the referral letter what was expected of the specialist:

- second opinion only
- treatment
- full work-up.

It showed that her confidence rate was that she, in a single-handed practice, felt competent to deal with approximately 91% of cases, broadly speaking.

It also gave her feed-back of what direction her continuing medical education should take.

Dr Mave O'Regan a GP in Fish Hoek did a *pathological referral audit:*

Her project was an evaluation of the number, type and results of specimens sent to a pathological laboratory, but excluding histological requests. This audit was undertaken because she had felt, during her student days, that many investigations were requested unnecessarily and thoughtlessly and she wanted to determine what investigations were being sent from the practice in which she was working and whether or not they were really helpful. She felt that each investigation should answer a specific clinical question relevant to the patient.

A total of 119 investigations were requested over a three month period, on 90 patients. Of the 119 investigations, 47 (39,5%) gave abnormal results, but often, of course, a normal result was helpful in excluding a suspected condition.

She found that undertaking this audit made her evaluate her reasons for doing investigations. It also made her consider the cost to the patient.

The audit was not time consuming and could easily be repeated yearly to continue feedback by self audit.

Dr Dave Prestige did a study of 200 consecutive patient contacts. He found the following:

68 were male (34%)
132 were female (66%)

First consultation	168 (84%)
Subsequent	38 (16%)

Ages

1 - 4	4%
5 - 19	15%
20 - 44	58%
45 - 64	17%
65+	6%

The following was the breakdown according to 'systems':

Musculo-skeletal	16,5%
Respiratory	14%
GIT	12,5%
Genito-urinary	11%
Pregnancy	10%
ENT	8%
Dermatology	7%
Eyes	6%
Accidents	4%
Preventive	4%
Haematological	4%
Infections	3,5%
CNS	2,5%
Endocrine	1%

Referrals

Specialist	7%
Laboratory	7%
X-Ray	6%
Physiotherapist	2%
TB Clinic	0,5%
Patients handled without referral/ investigation	90%
Patients referred without investigation	4%
Patients investigated without referral	5%

In Summary

The benefits of audit against the time, cost and potential disadvantage fall into four broad groups:

1. Educational value
2. Improvement of efficiency of practice
3. Improvement of effectiveness of care
4. Reassurance to the profession and other bodies.

If we regard audit as the starting point for generating questions rather than supplying answers, then it will be seen in its true perspective.

The message is, present the data as carefully as possible, draw reasoned and tentative conclusions and enjoy the discussion that follows. From this many research projects will grow.

No practitioner worthy of his profession, can afford to ignore the benefits of audit. Up to now the average practitioner has been remarkably silent about his quality of care.

Today, with the high cost of health care, all of us must be accountable for our standards, for our methods and for our costs if we want any say in the future health care of this country.

References

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