Black looks . . . at audit

So long as they are not closely examined, most of us would assent to these two propositions:

- Audit is 'a good thing'.
- We should know what we mean by 'audit'.

But when we look at them together, it seems obvious that the first of them is contingent on the second; and the history of attempted definition in this area suggests that there may be hidden pitfalls, some of which have an ethical dimension. In the preface to his Dictionary, Samuel Johnson warned:

'Every other author may aspire to praise; the lexicographer can only hope to escape reproach, and even this negative recompense has been yet granted to very few.'

Braving the dangers inherent in discussing definitions, let me say at once that neither its derivation from accountancy, nor its currency in the 'Newspaper' of free market management, greatly endear to me the actual word 'audit'; 'quality control' has been preempted to an analysis of (largely industrial and chemical) process; and on the whole I would prefer the American term 'quality assurance', used by Gordon McLachlan in his Rock Carling Lecture of 1990. But for better or worse, the term 'audit' seems established; at least it is short. It also begs important questions:

- Audit of what?
- Audit by whom?
- Audit for what end?

Audit of what?

In relation to health services, there are at least two different possible objects of audit—clinical process and institutional performance.

Clinical process

The analysis of clinical process is a long-established discipline, in which the Colleges and the Health Departments have been engaged for many years. On the sound, if perhaps fortuitous, principle that a good place to start something new is where it appears comparatively easy to organise, the first steps in quality control were taken during the war in relation to laboratory estimations, which can be assessed on test samples, replicated, and scrutinised on a quantitative basis. This activity began before the Royal College of Pathologists was founded, but has continued under its auspices; and is now an established part of both training and practice in NHS laboratories.

In the systematic scrutiny of strictly clinical results, which are of course less readily made quantitative even in groups, still less in individuals, the pioneers were the obstetricians, in their survey of maternal deaths which was supported from its early stages by the Health Departments. More recently, anaesthetists and surgeons have undertaken a similar study of the outcome of surgical procedures—on the face of it, a more difficult enterprise than the analysis of obstetric deaths, because of greater variability both in the clinical problems and in the previous health of patients involved. These difficulties are still greater in relation to 'medical' illnesses; but the Medical Services Study Group of the Royal College of Physicians, with support from the Nuffield Provincial Hospitals Trust, has made forays into this difficult area, with the object of improving practice by comparing outcomes of different methods of treating comparable conditions. But the spectrum of medical illnesses is even wider than that of those conditions for which an operation can be justified—a consideration which is also relevant to the audit of institutional performance.

'All happy families are more or less like one another; every unhappy family is unhappy in its own particular way.' Similarly, when the audit of clinical process and outcome shows them to be satisfactory, no great ethical problem arises. But what if not? The reasons for unacceptable clinical practice are legion, and they raise quite different ethical dilemmas. Doctors can make mistakes for a variety of reasons; they may be sick in body or mind; they may be working for excessively long hours; they may not be adequately supported or equipped; they may have failed to 'keep up', or simply have been swamped by an ever expanding knowledge base whether in general medicine or in their specialty; or they may have allowed the grain of good practice to be choked by the tares of other pursuits—of which budget-holding and contract management might be topical examples. Fortunately, this is not the place to suggest remedies for these different situations. My own bias is to rely more on good training, continuing education, and emotive encouragement than on periodic witch-hunts and recertification; but of course there are doctors who must, as with dangerous drivers, be prevented from doing harm. A further, confessedly defensive, consideration is that while doctors can certainly make mistakes, they are also capable of not making them, nor have they a prerogative of making mistakes.

Institutional performance

I incline to believe that whereas doctors and other health professionals may think of audit as related to

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clinical process, politicians and administrators think of it as a measure of institutional performance. That institutions should be open to appraisal must be common ground; but there are great difficulties in devising an equitable calculus of appraisal, and a calculus which is not equitable is by definition unethical. The difficulties lie in the inadequacy of the knowledge base on performance; in a narrow approach to the problem; and in the great inherent diversity in what might constitute ‘a good performance’ for different institutions.

The procedures of ‘hospital activity analysis’ and ‘performance indicators’ are confined to process, and give little if any indication of whether outcomes are satisfactory. The attempt to compare the performance of institutions is of very recent development compared with the assessment of clinical process; and there is a long way to go, at far from negligible expense. Later on, I shall give a view on the aim of the process, and on whether it justifies the substantial cost of the enterprise. Meanwhile, study of the methodology may be justified, and would certainly be better than stretching every hospital in the land on the rack of untested methodology.

The concept that ‘market forces’ will suffice to winnow good institutions from bad is perhaps grotesque rather than specifically unethical, though it may be that as well. Just as the Rothschild ‘customer-contractor principle’ of the seventies was perhaps applicable to military procurement but not to medical research, so the idea that the most ignorant can make the best choices is basically unsound—choice, like consent, has to be ‘informed’. I am not here criticising the greater choice allegedly given to family doctors, who have saved the service unacknowledged millions by responsible exercise of the ‘gateway function’ to tertiary care; but the transfer of final responsibility for choices in clinical activity to managers, and specifically to managers who may be obsessed with short-term profitability, establishing marts and cutting services. It is a principle of health economy that all costs and all benefits must be taken into account. Transfer of costs from hospital to community may benefit ‘the books’ in the hospital, but someone still pays, whether it be the community service or, more likely these days, the patient and family in ‘social cost’.

The outcome statistics of a hospital can very largely be explained by the characteristics of the groups of patients who enter it. What happens in any episode of illness is determined less by the treatment given than by the nature of the illness itself, the age of the patient, his/her social class and previous lifestyle. In one American study, ‘disease factors and admission severity accounted for 70% to 90% of the variation in outcome’. There is real difficulty in constructing an information system which incorporates these highly relevant patient attributes; is sufficiently accessible and ‘user-friendly’ to be actually useful; but at the same time maintains confidentiality at a standard acceptable for personal health information.

Audit by whom?

The central role of doctors in the audit of clinical process seems obvious. But their role in the audit of institutional performance needs discussion. The importance not just of the immediate illness, but also of previous characteristics of the patient, in determining outcome would seem to me to call for participation by those trained in clinical medicine and also by those trained in public health medicine. They should, however, be acting in an advisory capacity on these particular issues which, while important, are certainly not the whole story. Obviously, money cannot be neglected; and the discipline of accountancy must be involved; but again, money is not the whole story. For a perspective which seems willing to accept advice on the clinical aspects, and to take into account unquantifiable as well as pecuniary costs and benefits, I would myself look to health economics rather than to ‘business’ or ‘management’ skills.

Audit for what end?

What contribution, if any, can the results of audit make to the wearisome debate between those who blame the admitted inadequacies of the NHS on ‘under-funding’ and those who blame them on ‘inefficiency and waste’? The most likely general contribution may be to clothe in actual figures the common-sense suspicion that Tweedledum and Tweedledee are both right. It would indeed be a miracle if waste and inefficiency could not be found in any organisation of the size and complexity of the NHS. But it is also true that we spend only about a third of what Americans spend on health care, and substantially less than other EC countries. But to the large debate on health spending, I see audit making only a marginal contribution. In no way does that make it unimportant. When applied to the processes of health care, it can lead to important improvements in quality, both in relation to recovery from illness, and to decent standards in delivery of all aspects of personal health care, not just the directly therapeutic. And when applied to institutional performance, a comprehensive audit may show where administrative practice can be improved, and possibly even make an input to the very difficult task of ranging health care options in priority ranking. Comprehensive audit should, however, include not just that outcome unequivocally declared in mortality, but also degrees of morbidity and disability in those who survive.