GENITOURINARY MEDICINE

Editorials

Clinical audit in genitourinary medicine "Why, Who, What, How and When?"

Clinical audit, the systematic critical analysis of the quality of health care, including the procedures used for diagnosis and treatment, the use of resources and the outcome for the patient, is an essential component of medical practice for all those eager to provide the highest standards of care. Well conducted clinical research informs us how best to manage our patients but audit tells us whether we are actually doing it. Audit provides education for all those involved and by questioning all aspects of practice enhances efficiency.

Less noble motives for audit include its requirement for the securement of contracts and for the approval of training posts, its inclusion in the job description of recently appointed consultants and a commitment by Britain to an agreement that all European World Health Organisation member states should have built in effective mechanisms for ensuring quality of patient care.

The Royal College of Physicians of London (RCP) has stated that all doctors should participate in audit.¹ Thus each department must arrange a meeting time to allow attendance by all doctors. This may mean closing clinics early or opening late. Times must be chosen to give maximum opportunity for attendance by clinical assistants and part time staff who may form a substantial part of the medical team. Genitourinary medicine (GUM) is a multi-disciplinary speciality and we benefit by considering *clinical* audit not just medical audit. Therefore, Medical Laboratory Scientific Officers, Nurses, Health Advisors, Clinical Psychologists and other health professionals involved in our patients' care should be encouraged to attend and participate.

The audit of certain topics will benefit from outside assessment by specialists in other fields, such as gynaecologists, urologists, dermatologists. Smaller clinics may need to join with other local clinics to provide sufficient diversity of experience and opinion. Regional Specialist Advisory Committees should also encourage regular larger audit meetings so that the best audit practices may be abstracted and disseminated. Ultimately regional management guidelines may be formulated as recommended by the Royal College of Physicians of London.¹

Money has been topsliced by regions for audit and is largely being spent on information technology systems but this must not be assumed to be the only use. Specialist audit officers can help departments to set up meetings, select topics, abstract data, present it in a meaningful manner and document meetings. Each department should appoint a consultant to oversee audit and chair the meetings.

Clinical care may be divided into structure, process and outcome: the Donabedian Triad. Audit of "structure", the building, equipment and staff available may reveal prob-

lems but these are not always easily improved. Outcome naturally provides the best measure of the quality of care but may be difficult to define, (for example, what is the desirable outcome of pre-test counselling?) or difficult and lengthy to measure (for example, the maintenance of fertility by timely treatment of chlamydial infection). For these reasons we must rely on published clinical research to provide guidelines as to those processes which will optimise outcomes.

Topics suitable for audit should be high volume or high cost, easily definable or assessable, have defined standards, be amenable to change, show wide variation in practice or be the cause of local concern. By contrast clinical rarities with no agreed standard management (the usual subject of grand rounds) are not suited to the audit process. Suitable topics in genitourinary medicine falling into one or more of the above categories are urethritis in men, the use of acyclovir, the treatment of warts and the management of the asymptomatic HIV antibody positive patient. The preventative role of genitourinary clinics is particularly difficult to measure in terms of outcome and aspects of the process, (for example referral to Health Advisors, availability of written information, distribution of condoms) must usually be measured as proxies.

Patient satisfaction questionnaires are time consuming to prepare, distribute and evaluate but can provide important information not obtainable from routine case notes. Genitourinary physicians may liaise with other hospital initiatives although these may need to be modified to suit a genitourinary clinic. Clinical Accountability Service Planning Evaluation (Caspe) are preparing a patient satisfaction questionnaire specifically for use in genitourinary clinics.

The process of audit "set standards—observe practice and compare with standards—implement change—back to set standards" has been recited in every paper and lecture on audit for the past few years. In practice setting standards must involve written clinic guidelines for the management of all commonly encountered syndromes and diseases. Without these there is nothing against which to compare practice. Guidelines do not compromise individual clinical autonomy as they can be overridden whenever the clinical situation demands.² The mere process of writing such guidelines is an educational process in itself.

One of the simplest forms of audit is a review of randomly selected case-notes. Unfortunately this quickly becomes boring as common conditions and common failings are discussed over and over again. Variety may be introduced by choosing a particular aspect of the notes, for example, adequacy of history taking, appropriateness of antibiotic prescribed, documentation of information given

to patient, timeliness and content of reply to referring doctor.

For a more in-depth audit of a particular topic criterion audit³ provides a means of rapidly reviewing large numbers of notes. For a chosen topic a minimum list of criteria are specified and their absence or presence in each set of notes tabulated. This documentation may be done by a non-medical person (for example, an audit officer). The results provide a quantitative measure of the adequacy of the process. This can be compared over time and the success of any intervention measured. This method is especially suited to many topics in genitourinary medicine. Certain aspects of care, (such as, waiting times or sensitivity of microscopy) will require special investigations.

Whatever the chosen method of audit the meetings must remain non-threatening and non-confrontational. The purpose is to educate staff and improve standards, not to expose individual's bad practice. The audit chairman may, however, need to speak to individual doctors who persistently fail to follow agreed guidelines.

The audit process should be carefully documented to allow comparisons over time (and thereby demonstrate improvement – audit of the audit process!) to provide evidence to purchasers and managers and for approval of junior posts etc. Some audit exercises are worthy of publication. Confidentiality is not an issue as audit

meetings and minutes need never use patient (or doctor) identifying details.

The joint working party set up by the Standing Advisory Committee in Genitourinary Medicine and the RCP recommend at least monthly meetings. Certainly, less than this would mean that it might take many years to audit all aspects of care. Much more frequent meetings with the required preparation and discussion time would start seriously to interfere with other aspects of clinical work.

A pre-requisite to successful audit is an intention to improve standards driven by an honest admission that our care is rarely perfect. Audit is not a panacea but if we, as clinicians are seen to be reluctant to evaluate the service that we provide we should not be surprised if our patients, or the purchasers of our health care insist on doing it for us.

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- 1 *Medical Audit. A first Report.* The Royal College of Physicians of London. Mar 1989.
- 2 *Quality Management in the NHS: the doctor's role.* *BMJ* 1992; 304:304–8.
- 3 *Criterion based audit.* Shaw CD. *BMJ* 1990;300:649–51.

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