

ISSUE M. REVIEW OF CASES AND MEDICAL AND CLINICAL AUDIT

1. Hospital consultants have always reviewed outcomes for patients in their care, particularly within teaching hospitals and within each of the newer specialties such as paediatric cardiac surgery. Such reviews have consisted of individual personal monitoring of patient care, group review within specialty and discussions beyond the confines of individual districts, at regional, national and international meetings. A substantial proportion of the medical literature is made up of the publication of detailed reviews of series of patients who have been investigated or treated.
2. In the late 1980's there was a move towards formal audit, both at regional and at national level, with the publication of documents such as "Better Patient Care" and a Government White Paper called "Working for Patients".
3. In March 1989 the Region issued preliminary guidelines about the Regional approach to audit, called "Principles for Setting up Medical Audit"¹, which defined medical audit as "a systematic approach to the peer review of medical care in order to identify opportunities for improvement and to provide a mechanism for bringing them about."
4. I believe that the ultimate aim of audit was always that there should be continuous monitoring of the outcomes of treatment and care against agreed standards. The benefits to patients of such a system are obvious, and I was always keen that this final goal should be achieved. However, from the start, I was aware of a strong feeling within the medical profession that audit was going to be used as yet another management tool and I felt that its introduction to the formal structure of Bristol and Weston Health Authority, as it was at that time, and then the UBHT, needed to be handled very carefully in order to encourage doctors to participate. (This was at a time of great change in the NHS generally and there were already strong feelings and a great deal of sensitivity about the increasing role of managers in healthcare.)
5. The guidance emanating from the profession at this time emphasised that it was for doctors to take corporate responsibility for clinical care in terms of outcome measurements, and it was for management to facilitate the conduct of audit and to respond to the conclusions from audit but not to involve themselves in the audit itself.

¹Annex B to Appendix 1

Those conducting audit were required to identify any management action that was necessary as a result of an audit and then to inform management. Essentially, audit was seen as a professional activity which should be led by the profession.

6. Regular reports were to be made to the medical staff and to the regional health authority for the purpose of demonstrating that effective audit was being undertaken and it was not envisaged at the time that management would be given the data underlying or produced by audit. The reports were to demonstrate that audit was developing and that audit meetings were taking place, to give some information as to the subjects that were being reviewed, to identify any action that was needed and to give reassurance that the quality of care was improved as a result.
7. I always felt that, as an experienced doctor who had moved into management, any attempts by me to involve myself in the process or details of audit would have been seen as particularly threatening by those doctors who were concerned about the introduction of formal audit. I was concerned that unless I was very careful to follow the guidance, I might cause some doctors to oppose and therefore delay the implementation of audit, which would not have been beneficial to patients.
8. In June 1989 the South Western Regional Hospital Medical Advisory Committee issued a document entitled "The Regional Approach to Medical Audit" (Appendix 1). The RHMAC made arrangements for audit through the hospital medical committee and although, as a manager, I was kept informed of what was taking place, I was not involved in the arrangements.
9. Audit took place on a specialty basis, with each specialty committee or division taking responsibility for deciding how audit was to be arranged and the resources required in terms of clinical time, clerical and secretarial support, information technology and training and education.
10. In Bristol a Medical Audit Committee was set up towards the end of 1990, reporting to the Hospital Medical Committee as one of its sub-committees.
11. The Medical Audit Committee was chaired by Dr Trevor Thomas, an anaesthetist, and was responsible for facilitating and monitoring of the whole audit process. It had, necessarily, a co-ordinating and an advisory function, within the overall system in which responsibility was delegated to clinical directorates. It did not form a management structure for audit which was separate from the management of patient