

### **3 Participation in medical and clinical audit**

For over 20 years doctors have been participating in local and national audit activities. These have become considerably more sophisticated, particularly as the need to test the use to which results were put was built into the design of individuals' audits. The commitment of the profession was demonstrated in its support for the National Centre for Clinical Audit (NCCA), a multi-professional body, led by doctors.

But clinical and medical audit has, despite this enthusiasm, largely failed. Too often doctors are given no adequate markers against which they can audit their work. Too much of audit has been based upon outputs in the absence of meaningful clinical outcome measurements (except patient death rates). The opportunity presented by the White Paper's emphasis on ensuring quality must be used to relaunch clinical audit and to re-enthuse the profession about its value.

The development of outcome measures, a clinician led initiative, brings such an opportunity for more effective audit. It will allow audit to be repackaged and redirected so that doctors can see that it is related and relevant to the quality of care received by patients. Outcome measures and service frameworks are the most useful markers for measurement against others. Audit must also be supported by the resources required for it to be adequately performed.

There is already considerable peer pressure to take part in audit and related activities (including "grand rounds" in hospitals). Failure to take part in these may demonstrate that an individual is failing to consider his/her own educational needs and the standards of his/her practice. Dealing with such failure is the most difficult challenge facing doctors; compulsion by the colleges or employers is unlikely to be necessary once the systems are improved and the culture changed.

### **4. Participation in the establishment of national standards and good practice**

Through participation in bodies such as the Clinical Outcomes Group and the Standing Medical Advisory Committee, the profession has encouraged best practice recommendations in a variety of areas.

### **5. Current Professional activities**

A number of initiatives have been taken throughout the profession to ensure that doctors locally are aware of their obligations and of where and to whom they should turn if they have anxieties about a colleague's performance, health or conduct.

- The GMC's guidance, issued in July 1989 to doctors with managerial responsibilities, on how to manage doctors with problems has been distributed to all LMC secretaries and through the CCSC network.
- The British Medical Association and the Academy of Medical Royal Colleges have resolved to review and co-ordinate the way they offer assistance to trusts on problems relating to clinical governance. In general terms, the British Medical Association will continue to take the lead in advising on discipline and health problems and on matters relating to terms and conditions. Colleges are expected to have primary responsibility for responding to standards of care and clinical service problems. When the point at issue relates to clinical standards, either the quality of care offered by an individual or by a