Guest Editorial

Audit - Whither or Wither?

A statutory requirement to carry out audit was thrust upon the medical profession at the beginning of the decade by a government which was determined to curb the perceived power of the healing professions. The Secretary of State for Health was renowned for his pugnacity, and the profession had some difficulty in arguing against audit, which was defined in a 1989 NHS Review White Paper as '. . . the systematic, critical analysis of the quality of care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient.'

The term 'audit' has unfortunate connotations of bureaucracy, accountancy and external financial and managerial control. Alternative titles such as 'clinical effectiveness' or 'clinical quality assurance', which might have been more reassuring to the profession, and certainly more descriptive of the type of activity that should have been undertaken, were rejected by government. There was a deep suspicion that the hidden agenda for all this was another mechanism to save money and erode clinical freedom. After all, when everybody is engaged in audit, they can't be treating patients and using up resources, and the consultant who keeps his patients in hospital a day longer than all the other consultants must be made to 'toe the line' (even if his patients do have fewer post-operative complications than his colleagues). Certainly, the government provided some initial funding for audit, but the feeling was that this was 'the sprat to catch the mackerel'; and so, amidst an atmosphere of hostility, audit came into being.

The first problem was educational in that not everybody knew what audit was, nor how to do it. However there was no shortage of advice from government (1), the BMA (2), the Royal Colleges (3) and numerous courses or books by health economists, epidemiologists, clinicians and managers. We were given the now familiar 'audit cycle' as a model. When used to its logical conclusion it becomes a spiral and, like the bath water, it eventually disappears down the plug hole!

Whilst no one would argue with the basic concept of audit, i.e. improving patient care and conserving scarce resources, what in practice, has happened since the turn of the decade?

In my opinion, most of the audit activity performed in orthodontics has been of limited use, of questionable cost efficiency and in some cases has been downright dangerous. Let me explain. Many dental journals are being inundated with articles which are essentially 'written up' audit projects. Most are rejected for publication. Not simply because they are audit (a good audit project will always be considered for publication in any reputable journal), but because of poor structure to the project. There are several similiarities between an audit project and a clinical research project. They are both finding out processes, they both need careful planning, a written protocol and often will benefit from a small pilot study, they both need funding (usually), and they should both be properly analysed and written up afterwards. It is the differences between research and audit which are of concern. Research protocols are carefully scrutinised for good science and sound ethics, audit escapes this scrutiny (locally, projects have been returned by the Local Research Ethics Committee as 'audit', and therefore not their business); research is a voluntary activity whereas audit is compulsory; hospital authorities are anxious to ensure that audit is being seen to be done and like to see quick results (sometimes termed 'quick and dirty') which, in turn, means everyone is looking for something quick and easy to achieve (like a retrospective study of impacted canines), whereas research can have the luxury of taking a prospective, longer term, more strategic view of questions of clinical significance; and finally, we are expected to involve junior staff in audit (in other words, let's be honest, get them to do the work), and so, because they will be moving on to a new job, the project can't last more than a year anyway. The results of audit may suggest a change of practice which, after all, is it's main *raison d'être*. This change can be implemented immediately, regardless of the quality of the structure of the project, the quality or lack of statistical analysis, and without any form of peer review. None of this is possible with a research project. Prosecuting poor science, be it audit or research, is unethical as well as a waste of time and money; acting on the results of poor science can also be dangerous.

This is not to say that all audit is poor. There are many projects which have been planned and carried out in an exemplary manner and have contributed to patient welfare. However, clinical audit by the single handed consultant really gives little benefit either to the consultant or to society. The important questions of clinical outcome should really be dealt with on a regional or national basis. The current project organised by CSAG (BJO editorial May 1996) looking at the management of cleft lip and palate is a classical example of a national audit which is well organised, clinically relevant and will influence the way in which care is delivered in the future.

Wither audit? I think that it already is withering and the days of the 'bean-counter' are numbered. The value of audit has been the opportunity to allow busy hospital staff *time* to reflect on their clinical practice in a variety of ways, and hold meaningful dialogue on clinical problems with colleagues. The benefits of this aspect should be recognised, and not be allowed to wither.

Whither audit? The growth of clinical effectiveness as a means of replacing the time and money that has hitherto been put into audit is probably a good thing. If nothing else, the title more accurately reflects what I would like to be doing.

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1. The Quality of Medical Care. Report of the Standing Medical Advisory Committee. 1990. HMSO London.
2. Audit in Action. R. Smith (Ed). 1992. British Medical Journal.
3. Guidelines on Audit in the Dental Specialities. 1990. Faculty of Dental Surgery Royal College of Surgeons of England.