

TIME FOR MEDICAL AUDIT

Pages with reference to book, From 1 To 2

Mumtaz Maher (Department of Surgery, Jinnah Postgraduate Medical Centre, Karachi.)

The quality of medical care broadly depends upon three factors: the organisation and its staffing, the type and standard of clinical work carried out and the outcome of such service. These three factors are in turn influenced by the needs of the society and the prevailing socio-economic circumstances. Considering these three factors it becomes obvious that what falls in the domain of the clinicians and ultimately their responsibility is the type of clinical work done and the outcome of such service. Terms used for these two aspects are 'process' and 'out come'. Medical audit is used chiefly as a means of assessing process and outcome. See defines Medical audit as "the evaluation of the quality of medical care as reflected in the medical records". The term "audit" ---- more usually associated with accountancy ---- implies numerical review by an outside investigator directed at, among other things, the prevention of fraud¹ but in the clinical setting medical audit is the collection of data for purposes of i) setting professional standards, ii) assessing clinical performance, iii) modifying clinical practice. In the United Kingdom the medical royal colleges and speciality faculties increasingly require evidence of audit before accrediting posts for specialist training and, medical audit will become compulsory in the regional and district hospitals by 1991³. In the U.S.A. hospitals are required to have an audit procedure to obtain accreditation from the American Joint Commission on Hospital Accreditation. In recent years medical audit has been introduced in the wards by many British surgeons⁵⁻⁸. It has also been carried out from time to time in Pakistan⁹. Isn't it time to formally introduce medical audit in teaching hospitals in Pakistan? Medical audit is more systematic, quantified and formal than traditional clinical ward rounds, meetings and case presentations. It has shown to provide, educational benefit^{10,11}, guidelines of management¹²⁻¹³, improvement in care of patients¹⁴ and in one case a hospital managed to acquire an intensive care unit on the basis of the findings of medical audit¹⁵. With multiple postgraduate centres established in Pakistan it is imperative that continuing medical education of physicians and surgeons be established in a controlled form. Traditionally retrospective surveys have formed the basis of original articles, lectures and presentations at seminars and conferences. Sometimes the findings of these surveys have led to a change or improvement in the diagnostic technique and treatment. Such improvements in postgraduate education can be brought about through medical audit if doctors accept a more open attitude towards what they do and be willing to discuss the management of patients with their colleagues¹⁶. Thus deciding whether one is for or against medical audit is as meaningless as deciding whether one is for or against research¹⁷. Should collection of data for medical audit be retrospective or prospective? The problem with collection of retrospective data is that it can be a demanding task which more often than not is delegated to the most junior member of the staff, with adverse effects on its accuracy and completeness. For an audit to be complete it is important that it be prospective, and details of patient care and complications are recorded as they occur. An audit should be planned and if possible the aid of a computer be sought so that information is coded for easy recording and retrieval. In this issue of the journal Khan et al¹⁸ present an audit of a large number of admissions to the recovery room following surgery. This paper highlights the need for an adequately staffed and equipped postoperative recovery room. It also brings to our attention the fact that following surgery a number of remediable but potentially lethal complications can take place. It is time that we teach people to conduct and accept audit as a constructive exercise. It is time the medical profession is seen to examine it's work more critically.

REFERENCES

1. Shaw, C.D. Aspects of audit. 1. The background. *Br. Med. J.*, 1980; 280:1256.
2. Sanazaro, P.I. and Worth, R.M. Concrovient quality assurance in hospital care; report of a study by private initiative in PSRO. *N. Engl. J. Med.*, 1978; 298: 1171.
3. Shaw, C.D. and Costain, D.W. Guidelines for medical audit, seven principles. *Br. Med. J.*, 1989; 299: 498.
4. McWhinney, I.R. Medical audit in North America. *Br. Med. J.*, 1972; 2: 277.
5. Gough, M. H., Kettlewell, M.G.W., Marks, C.G., Holmes, S.J.K. and Holderness, J. Audit; an annual assessment of the work and the performance of a surgical firm in a regional teaching hospital. *Br. Med. J.*, 1980; 281:913.
6. Matheson, N.A. and Valerio, D. Large-bowel surgery, 1970; self assessment. *Br. Med. J.*, 1980; 281: 719.
7. Seymour, D.G. and Pringle, it A new method of auditing surgical mortality rates. Application to a group of elderly general surgical patients. *Br. Med. J.*, 1982; 284: 1539.
8. Roy, A.D., Parks, G.T., McKelvy, S.T.D., Odling-smee, W. and Deans, G.T. Auditing perioperative mortality. *Ann. itColl. Surg. Engl.*, 1987; 69:185.
9. Junaid, I., Qureshi, H., Hassan, A. and Ahmed, M. Pattern of admissions in a general surgical unit. *JPMA.*, 1982; 32: 187.
10. Qureshi, H., Banatwala, N., Zuberi, S.J. and Alam, E. Emergency endoscopy in upper gastrointestinal bleeding. *JPMA.*, 1988;38:30.
11. Qureshi, H., Zuberi, S.J., Banatwala, N., Anwar, A., Shamsi, Z. and Naemullah, M. Ulcerative colitis in Karachi. *Gastroenterol. Hepatol.*, 1989; 4: 313.
12. Fielding, L.P., Stewart- Brown, S., Blesovsky, L. and Kearney, O. Anastomotic integrity after operations for large-bowel cancer, a multicentre study. *Br. Med. J.*, 1980; 28: 411.
13. Qureshi, H., Zuberi, S.J., Banatwala, N., Alam, E. and Faruqui, A. Propranolol in bleeding oesophageal varices. *Pakistan. J. Med. Res.*, 1989; 28: 16.
14. Shaw, C.D. Aspects of audit, 4. Acceptability of audit. *Br. Med. J.*, 1980; 280: 1443.
15. Gilmore, O.J.A., Griffiths, N.J., Connolly, J.C., Dunlop, A.W., Hart, S., Thomson, J.P.S. and Todd, I.P. Surgical audit; comparison of the work load and results of two hospitals in the same district. *Brit. Med. J.*, 1980; 281: 1050.
16. Walter van't Hoff: Welcome for Medical audit. *Br. Med. J.*, 1989; 298: 1021.
17. Anonymous. Audit; aiming high. *Br. Med. J.*, 1981; 182:422.
18. Khan, A.F., Soomro, N. A. and Kamal, R.S. A review of 6978 consecutive admissions to the recoveiy room at a university hospital. *JPMA.*, 1991; 41 : 2.