Clinical audit can be fun!

In this guide to the craze that's sweeping the country, Dr Jon Garvey offers a survival kit for audit

SO MUCH has been written about clinical audit that, like abortion or apartheid, it has become virtually impossible to discuss rationally.

Those in favour are becoming increasingly categorised by their opponents as trendies and empire-builders, and quickly reinforce this view by making trendy, empire-building statements and categorising those against as die-hard reactionaries.

Among those in favour are clinicians who revel masochistically in having their faults revealed for all to see, and would rather be shown by their trainee to have missed a simple diagnosis than to have spotted a rareoneanyday.

The sadistic end of the spectrum includes those who thought of the idea, as they are almost bound to end up as auditors.

What would it all be like? All the welter of suggestions and schemes only serves to convince me that, however well-intentioned its originators were, the whole thing will be organised like scientology, with lie-detectors being carted around from practice to practice in the hope of relieving benighted GPs of their clinical 'engrams'.

To reduce the ill-effects of this as far as possible I offer this small survival kit for clinical audit, until such time as one greater than I organises an audit survival steering committee in conjunction with a national network of audit shelters.

The advantage of the following techniques is that they may be used whatever sort of audit is imposed, from gentle discussion with one's partners, or 'peer-group audit' — once called 'back-biting' — to encounters with some faceless man from the DHSS mumbling about cost to the taxpayer.

LAME EXCUSES

These provide very good holding tactics of almost infinite variety. For example, one can use the particular characteristics of one's practice to justify nearly every sort of clinical behaviour.

'Our patients are mainly from the upper social classes, and therefore I always prescribe antibiotics for colds because they have high expec-tations', or 'Our patients are mainly from the upper social classes, and therefore I never prescribe anything for anything because they understand explanation of their condition'.

Such excuses will rarely produce outright victory, since any auditor worth his salt will be able to prove that Dr Blogg down the road has even higher-class patients than you and does the opposite.

However, you can spend many sessions trying it on with different patient-groups —older, younger, less privileged, more privileged, immigrants, emigrants and so on — without even having to think of other types of excuse, such as large list size, small list size, too few/many partners, inadequate premises and so on.

When your auditor finally tires of these, it is time to hit him below the belt with the second technique.

TURNING THE TABLES

The idea is to shift the blame for poor management or practice on to the inquisitor. There is no defence. Try this one: 'We haven't got time to look after the books properly because we're too busy seeing patients.'

Even better: 'I suppose our prescribing costs are the highest in southern England because we are a caring practice.' This implies hard-heartedness not only in the auditor but the entire medical profession and, again, can justify any malpractice you care to mention.

Emotive phrases come in very handy here, such as 'family doctoring', homely if ungrammatical, or, if one leans towards the modern, 'whole-person primary healthcare at the point of contact', which means exactly the same thing, i.e., nothing.

Prescribing habits are likely to be one of the most accessible areas for audit, especially if the authorities get a look-in. A defence, though of limited value, when challenged on using expensive drugs, is:

'MY PATIENTS DESERVE THE BEST'

This will suit the sort of chap who does not read "Drugs and therapeutics bulletin" on the grounds that it is compiled by a group of dusty gentlemen, probably Scots, who meet round an oak table in a library somewhere, saying 'humbug' whenever a new drug emerges.

They are so mean they can afford neither pictures nor a printer, and have only a typewriter. Not surprisingly, our genial GP prefers to learn his therapeutics from the farmore lucid and informative advertisements in the journals: 'Arthren actually *digests* plasma cells that other anti-inflammatories leave behind' or 'Nine out of 10 doctors prefer Pololol, the beta-blocker with the hole.'

Unfortunately, all auditors take "Drugs and therapeutics bulletin" instead of the "Sun", and start quoting clinical trials and other irrelevancies. If all else fails, one may resort to:

BIGOTRY

This is the medical equivalent of the politician's marginal note: 'Argument weak here: shout louder.' It is to be used towards the end of a session of audit, after prolonged arguments, and is usually best introduced in some statement such as 'Well, I've done it this way for 35 years, and I'm not going to change now'. Said with feeling, it can even sound convincing, and will certainly defeat your opponent —unless he has the power and inclination to have you struck-off. So you see, clinical audit need hold no terrors for the doctor conscientious enough to prepare himself.

Jon Garvey is a GP in Chelmsford, Essex.