inexpensive. Provision of administrative staff by management would be of benefit. Frequent meetings, occurring at least monthly, would maximise the value of audit and reduce its perceived threat. Furthermore, we recommend that no formal records be kept until the medico-legal implications are clarified.

Case note review is probably the best initial step, and the case notes should be selected at random by an independent chairman; each case should be presented by the doctor best acquainted with the case. When the practice of audit has become established, other topics such as out-patient care, management of suicide, parasuicide, and detained patients could come under focus. The experience of the Southampton team suggests that while standards of note-keeping is important, it is vital that it does not overshadow consideration of the overall quality of care (Edwards *et al*, 1987).

In conclusion, the importance of audit in psychiatry cannot be overstated. Its institution in an appropriate and sympathetic way is likely to guarantee its success, and thereby to affirm its place within our everyday practice.

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Medical audit in psychiatry

or **Fear and loathing on the White Paper trail**

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The Government White Paper, *Working for Patients* (1989), although presented as a discussion document, should be seen as a position paper. It is clear that the government intends to implement the major proposals, and will be able through its control of general management, enhanced by a stream-lined management structure (*Working for Patients* para 2.3–2.11), to put pressure on health authorities to take action accordingly.

Psychiatrists should not allow the placing of mental health services in the 'core services' (*Working for Patients* para 4.15–4.18) to lead them into complacency. Reading the White Paper in conjunction with *Community Care: Agenda For Action* (1988) makes clear the likely direction of future policy. Once the general acute services are established in their semi-autonomous NHS Trusts, they will be encouraged to tender for the acute aspects of mental health

(*Working for Patients* para 4.17). The residual areas of mental health can then be assigned to community, and thus Department of Social Services, responsibility (*Agenda for Action* para 4.7–4.8 and 4.11–4.15). Psychiatrists would then be expected to hand over primary responsibility for the care of their patients to social services departments at whatever point in their treatment they leave 'acute' care.

This may or may not be a satisfactory approach to the problem of providing mental health services. Nevertheless, it is unlikely that the long looked-for appointment of a Minister of State with responsibility for community care and the drafting of legislation (*Agenda for Action* para 7.2–7.4) has simply been forgotten – Sir Roy Griffiths is still *in situ*. Enactment of the major proposals in the White Paper will clear the way for movement on Community Care, so look out your copy of *Agenda for Action*.

The question for psychiatrists is where we think the line should be drawn between acute and long-term care, as this will define the area for which we will have primary responsibility. And if we can agree on that, how to convey the clinical sense behind this to potential managers and to government. The unprecedented way in which the British Medical Association has not even been asked for an opinion on the contents of the White Paper before publication indicates that the Government is unlikely to treat its eventual response with any more interest than it has shown in the opinions of other 'trades unions'. The authority of the Royal Colleges to express opinions on clinical matters, and to safeguard training, has, however, not yet been eroded. Our College should now set about establishing accepted principles of psychiatric care which indicate the responsible limits of a psychiatrist's practice.

When the going gets tough . . .

"Medical Audit is a fundamental principle of the review" (*Working for Patients* para 10.10). "The Government will also encourage all the Royal Colleges to make participation in medical audit a condition of a hospital unit being allowed to train junior doctors" (*Working for Patients* para 5.6). These statements in conjunction with the proposed changes in the management of consultants' contracts so that individual consultants will be employed with a specific job description they will be expected to fulfill (*Working for Patients* para 5.12) indicate that we will need to be prepared to explain in some detail to our managers (usually not medically qualified) the basis upon which we make our clinical judgements and management decisions.

The Working Paper on Medical Audit (*Working for Patients* Working Paper 6, *Medical Audit*) emphasises this, and sets out a timetable whereby each health authority should by April 1991 have in place a District medical audit advisory committee. Every doctor will participate in audit, and the Committee will plan and monitor a comprehensive programme of audit, and produce reports available to health authorities considering placing contracts with the district. "Particular problem services" may be independently audited at the behest of a Regional Audit Advisory Committee.

Consultants can expect to have their clinical activity subjected to unprecedented scrutiny, by clinicians "the system should be medically led" but on behalf of managers. So whatever answer we choose to give to the question as to where the limits of our responsibility lie, and how we work within those limits, we must expect to be able to justify it. To justify it in terms of cost and effectiveness at first appointment to a consultant post, and at each annual audit.

Hoffenberg (1987) in his discussion of clinical freedom warned:

> "If we agree that standards of clinical competence should be appraised; that patients themselves are not favourably placed to make such judgements; that attempts by administrators to assess quality of care are likely to be based on unacceptable and often irrelevant quantifiable criteria; and that only doctors themselves have the appropriate insights into the competence of their colleagues; then the need for doctors to establish their own systems of monitoring seems ineluctable."

I would only add that the first postulate is no longer open to debate.

. . . the tough get . . .

The type of audit apparently envisaged in the White Paper bears much resemblance to that in North America. Hoffenberg (1987) traces the development of audit there from action taken by the Federal Government in response to rising medical costs. Peer review was instituted at first, to be followed in 1983 by the system of diagnosis-related groups, each attracting a specific fee. The consequence of this was, of course, a rapid rise in the turnover of cases, with patients discharged precipitately. The emergence of Health Maintenance Organisations as providers of total medical care at a fixed fee is one solution to this problem, but in Hoffenberg's opinion at the cost of clinical freedom: financial control rules.

The other recently prominent feature of the peer review system in the States has been litigation under anti-trust laws, and consequent legislation to protect clinicians involved in peer review (Curran, 1987; Waxman, 1987).

These features of the American experience of audit probably represent the nightmare raised in some minds by the White Paper: that doctors will be set up to curb one another's clinical freedom in order to

contain central government costs. Clinical judgement will be forced to recognise cost before the needs of the case.

However, the report by Van't Hoff (1985) of his review of audit in a number of North American hospitals paints a more positive picture. Government control is prominent, with mandatory audit in the United States controlled by a Federal Commission. Adequate audit arrangements are a condition of a licence to train medical staff. Audit is basically a peer review, but appears to be focused on specific areas rather than being a systematic review of usual practice. In Ontario the Hospital Medical Records Service has developed 'Care Appraisal Programs', standards of practice in various clinical areas, which arise logically from the type of audit described.

The standard of staffing and the activities of medical records departments are reported generally superior to those in Britain. Notes are in some places systematically scrutinised for standard of documentation, and for evidence that investigations are responded to. One can see here the overlap with financial audit, but one is left with the impression that financial and clinical audit run more often in parallel. Perhaps one is seeing a virtuous spiral whereby concern for financial control has generated an interest in audit, whose independent clinical and teaching utility has then become apparent. It is clear even from this account that such a good outcome is at best patchy.

Australian psychiatry has started at the other, clinical audit, end of the path. Funded by the Australian Department of Health, the Royal Australian and New Zealand College of Psychiatrists has set up a project called 'Quality Assurance in Aspects of Psychiatric Practice'. The Quality Assurance Project (QAP) (1982) is developing a series of treatment outlines for the major psychiatric conditions as a basis for peer review and subsequent research. The treatment outline is based on three sources; a meta-analysis of the available outcome studies for the condition; a survey of the practice of a one in six sample of Australian psychiatrists; a consensus meeting of four nominated experts in the field.

The outline (QAP, 1983) is explicitly not an attempt to prescribe treatment, although it will set a standard against which to compare novel treatments. In fact it is notable for attempting to reflect good practice in the broadest way – including, for example, remarks on the quality of the doctor-patient relationship. There now exist QAP outlines for treatment of agoraphobia (1982), depressive disorder (1983), schizophrenia (1984) and anxiety states (1985). Less common or more controversial areas – such as the treatment of personality disorder – are not considered suitable for this process.

The value of such a base-line is apparent in Parker's (1985) measured response to the Proileau meta-analysis of psychotherapy outcome. Whatever the value of psychotherapy, he started from the position that competent psychiatrists are using it daily in their practice, so it was not simply a matter of taking a position for or against the article. It was necessary to digest the significance of the report to general psychiatric practice. The same buffering effect would apply in the face of pressure to change clinical practice for financial or structural reasons.

In Britain little progress has been made down the road to audit. Although there are some model elements of audit such as the Confidential Inquiry into Maternal Deaths, and the insistence by the Royal Colleges that trainees have the opportunity critically to appraise practice (Duncan, 1980), of the types of audit practised only peer review seems of direct relevance to psychiatry (Heath, 1986). Even that is far from widespread, although one account of its use in a psychiatric unit described it as a very positive step (Edwards *et al*, 1987).

Psychiatry has, of course, numerous examples of the assessment of treatments and interventions, but not of attempts to relate research studies to general psychiatric practice. Shaw (1980) has warned that audit is characterised on a continuum between informal, voluntary, educational and without sanctions at one extreme, and formal, statutory, regulatory and bearing sanctions at the other. There is an ominous feeling that without prompt action we will experience the latter end of the spectrum.

. . . *organised*

The first lesson to be learned, particularly from the Australian example, but also from the clinically-oriented end of the American experience, is that audit is not necessarily a monster. It can, in fact, be a useful means of promoting good practice and training by encouraging a questioning approach to medical custom. There seem few reasons other than anxiety about our competence why any of us should not answer the question "why did you do that?"; but it would be more welcome from a peer group than a government or management auditor.

In order to ensure some safety from being audited purely on a cost basis – any psychiatrist offering a cheap service could be preferred at appointment committees – we should embrace the idea of audit to establish sound clinical practice. Outlines such as those of the QAP would help a clinician protect elements of service on the basis that it is part of sound general psychiatric practice, rather than purely his or her own practice. They would facilitate reasoned questioning of a proposed novel service which carries a reduced cost, necessary if we are to guard against progressive paring away of service elements in the competition to maintain costs below average.

This is particularly important as audit is inclined to be insensitive to clinical outcome, while it is highly sensitive to structural costs (buildings, staff and equipment), and to process (what the structure does). The latter is the focus of performance indicators, which most readily reflect such matters as length of stay, bed occupancy and staff time use. The post-Körner Indicators are not expected until the summer, and the existing ones are unlikely to give much indication as to what they will include. They are unlikely, however, to reflect clinical outcome. Proper peer review procedures will enable us to discuss clinical outcome in various structural and procedural systems.

To allow this, however, the speciality will need to apply a high standard of self-monitoring, which in the first case means record-keeping. Care Plans have long been seen as part of good practice – they are taught to be desirable to trainees and expected in the Membership Examination – but are still not part of standard practice. The Mental Health Act Commission found it necessary to remark on this in its Revised Code of Practice (February 1988), and will now expect to see Care Plans in notes. We can no longer afford to be open to this sort of criticism, as without clear indications of the treatment policy being followed we cannot hope to demonstrate its effectiveness.

I suggest the following steps may help to maintain a clinical focus in audit:

(a) Care Plans should now be part of all clinical notes, being agreed at ward rounds and regularly reviewed. They should include details of the objective of each element of the intervention, and the staff involved. Reviews should include assessment of progress towards objectives.

(b) Peer review should be instituted to assess the use of Care Plans and the progress towards the use of objectives. This should allow discussion of the appropriateness of various objectives in a case.

(c) Registration of a post for training should be dependent upon adequate use of notes and peer review procedures.

(d) The Royal College should assess the value of a Quality Assurance Project on the lines of that in Australia, or other ways of establishing broad guidelines of accepted current practice for use in audit. It may be possible to persuade government to fund this (Working paper 6, para 3.4).

The time available is short – by 1991 the District should have its audit plans laid. We need before then to have made significant steps to safeguard standards of clinical practice in a world preoccupied with cost. Our speciality, of all medical specialties, must do what it can to protect itself from having its service broken down into economic units, between which continuity of care is likely to be lost.

I believe that sound audit can help us to establish the reasons for clinical measures, and benefit the quality of care we provide; and that unsound audit can be an attack upon that care. There is now no doubt that our work will be subject to audit: it is our job to ensure that it is of the first type.

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