Trainees' Forum

Contributions are welcome from trainees on any aspects of their training

An Attempt at Self-Audit

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Medical audit is currently the subject of much discussion, but the breadth and intensity of the debate should not obscure the idea of medical audit as 'basically a process of self-education' (Shaw, 1980a). The requirements for audit have been summarized as information, resources and willingness to participate (Shaw, 1980b). I have attempted to devise a simple scheme for self-audit in a general psychiatric setting. The acquisition of appropriate information within the resources of ordinary clinical practice was my aim.

Method

The patients chosen for the study were all the admissions over a five-month period to a small psychiatric unit and for whom I took day-to-day responsibility. I made my initial assessment during the first week of admission and a second assessment at discharge from hospital. During this time each patient was seen weekly by the whole medical team (consultant, SHO and myself as senior registrar) and individually by myself at other times. I assumed that any errors in my initial opinion would be corrected by the other psychiatrists thus involved. A third collection of data was made at out-patient follow-up. In order to keep within ordinary clinical limitations patients were discharged from the out-patient clinic as soon as they were fit. This restricted the period of follow-up for the study, but no patient was followed up for less than two months after the second assessment, and most were seen for four to six months.

All data were recorded under standard headings on an index card. There was a card for each patient and this was identified by their hospital reference number to safeguard confidentiality.

The headings used were:

1. psychiatric illness, qualified as definite, probable, possible; also a note of any complicating physical factors, e.g. probable depressive psychosis with hypertension;
2. personality, given as a short description;
3. environment, subdivided into home (including sexual), social (outside home but including sexual), occupational and financial;
4. proposed management for each of the above headings;
5. prognosis, a definite prediction of outcome within the study period.

Results and Discussion

Information was collected on 25 patients (9 men and 16 women). The largest group was of cases of anxiety neurosis (9 patients). The rest were accounted for by 11 other diagnoses, including both common (e.g. depressive psychosis, 3 cases) and less common states (e.g. pathological gambling, spasmodic torticollis, dermatitis artefacta, one case each). This spread of cases probably reflects the teaching function of the small unit where the study was done. Eighteen patients were followed up personally throughout; four others had been referred to the care of other practitioners after discharge from hospital but reliable information was available; three were lost completely to out-patient care and were excluded from further consideration.

The usefulness of these data for self-audit can best be presented by discussion of the important points which arose during my review of the cumulated information. It became clear that the only way to analyse the material was by individual headings; for example how reliable was my diagnosis of depressive illness? Unfortunately, the small number of patients limited the usefulness of my data; I could not assess my accuracy in the diagnosis of depressive psychosis, as I had only three patients in this category. Even when a broader approach is taken so that numbers become sufficient, the results are difficult to interpret. For instance, I looked at the accuracy of my prognoses in all patients. I found that my initial predictions of outcome had to be modified at follow-up in 7 cases: 4 were initially too pessimistic and 3 too optimistic. However, the modifications needed were only minor and I had no way of knowing whether 7 minor prognosis errors in 22 cases could be regarded as an acceptable level of performance. I was, therefore able to acquire no substantial information about any major trends in my clinical technique. To assume that I found no serious problems with my assessments because none existed would be unjustified on the data available. Nevertheless, the record cards allowed me to review each case quickly, and this was of some interest; for example, a patient diagnosed as having a schizophrenic defect state was eventually seen as depressed and treated successfully with ECT.

Conclusions

I have been able to draw some conclusions from this attempt at self-audit. It seems that large numbers of cases are needed; the time taken to collect these would cause difficulties to the many junior psychiatrists who change posts every six months. One possible solution is to do a series of audits each on a restricted topic, e.g. one's accuracy in pre-

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dicting response to treatment in all patients encountered. Another problem is the absence of normative data with which to compare one's own findings. The answer for this would be to compare findings with a senior colleague who had run a similar survey of his own work.

A high degree of co-operation and goodwill would be needed. Perhaps the major difficulty lies in the interpretation of negative findings; a self-examination which reveals no faults must be suspect. I tried to overcome this possibility by studying only patients who were seen regularly by my consultant, who would act as a corrective influence on my assessments. Further investigation into formal self-audit schemes would be valuable.

REFERENCES

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Report of a Session of the AGM, 1980

The Statutory Registration of Psychotherapists

At the recent Annual Meeting of the College in July 1980, the opening session was devoted to the issue of the statutory registration of psychotherapists—a topic at present keenly debated. (See discussion paper by Michael Shepherd, this issue page 166.) A general report of the session is printed below.

MR PAUL SIEGHART, Chairman of the Professions Joint Working Party, summarized the Report of that body published in 1978. Seven organizations, including the College, had representatives on the Working Party and four additional bodies sent observers. Mr Sieghart explained the difference between the two varieties of professional registration currently in use. Functional registration was appropriate where it was possible to define precisely the scope of the work, e.g. in dentistry or in optician practice. Indicative registration was where the statute protected names or titles, e.g. in medicine or nursing. A register of psychotherapists could only be indicative because of the great difficulty in delimiting the field. If legislation were enacted, it would be unlawful to state or to imply that one was a psychotherapist if not on the register. Control would be exercised by a Council (analogous to the GMC) who would protect the public against unqualified or unscrupulous persons, maintain standards, regulate training and prescribe a code of ethics.

The Working Party had reached agreement that registration was desirable, but the representative of the British Association for Behavioural Psychotherapy had entered a Note of Dissent in the Report.

DR IRVING KREEGER, who represented the College on the Working Party, was strongly in favour of establishing a register. After setting out the practical difficulty of identifying psychotherapists, he discussed the constitution of the proposed Council and emphasized the importance of regulating training, which he considered should be the principal criterion for registration. Despite the many varieties of psychotherapeutic work, there had been a remarkable consensus in the desire for legislation. He disputed the view that the registration process would split psychiatry and psychology so that those not on the register would cease to concern themselves with psychotherapy.

DR ANTONIA WHITEHEAD, the representative on the Working Party of the British Association for Behavioural Psychotherapy, was in favour of registration, but did not regard training as a suitable criterion. Subscription to a code of ethics should be a key factor. The other principal criterion should spring from the critical evaluation of a psychotherapeutic procedure as effective or not. She questioned sharply the value of training to carry out treatments of dubious validity. She believed that psychoanalysts tended to equate psychotherapy with the dynamic approach. Registration would be a costly undertaking, and she hoped that in the event it would truly serve to protect the public rather than the practitioner.

DR PAMELA MASON, speaking for the DHSS, said that the Government saw no objection in principle to a system of indicative registration similar to that provided for professions supplementary to medicine. However, such a system would not be effective in prohibiting or restricting the activities of dubious fringe bodies, and there would be the prospect of a never-ending list of additional protected names and titles. The potential value of the Report lay in the possibility of its commanding the support of the professions, including those not represented on the Working Party. The Report was not unanimous—the British Association for Behavioural Psychotherapy had dissented and had queried whether valid training could be defined and thought controls would be best applied by professional bodies, and the British Psychological Society did not necessarily share the Working Party's views. The issues were complex and there was a need for continuing discussion by the professions.

There was no Government time available for legislation. If a Private Member's Bill should seem likely, certain questions