

any investigative technique (radiologic “digital” v. surgeon “digital”) is lacking. I generally rely on my finger, corroborated by TRUS unless MRI or CT has already been done. This preference is entirely logistical, as locally I have easier access to TRUS than to CT or MRI.

Recommendation: Determine by available means if the tumour is a big, fixed mass that would be best treated with neoadjuvant therapy.

Caveat: With our evidence base so scant, consider participating in trials that may teach us more about appropriate staging.

Competing interests: None declared.

References

1. McMullen TPW, Easson AM, Cohen Z, Swallow CJ. The investigation of primary rectal cancer by surgeons: current pattern of practice. *Can J Surg* 2005;48:19-26.
2. Statistics Canada. Canadian cancer statistics 2004.

Audit to improve

John M.A. Bohnen, MD

*Vision without action is a daydream.
Action without vision is a nightmare.*
— Japanese proverb

Surgeons who have achieved practice perfection, read no further. The rest of us wonder how to maintain and enhance our performance according to expectations of ourselves and colleagues, and how to adopt “best practices” displayed in journals and education sessions. Achieving those goals challenges us because of competing demands on our personal and institutional resources, and because, frankly, we have not been taught how to do it. We engage in life-long learning of medical expertise, effective communication, accurate documentation and wise resource allocation, but we have not learned how to monitor and improve ourselves in those functions. Because data-gathering and accountability for our performance are increasing at local, provincial and national levels, we will face growing requirements to maintain and improve our practices,

and prove that we have done so.

To that end, Birch and colleagues¹ have served us well by providing a stepwise approach to one of Maintenance of Certification’s (Maincert’s) most difficult yet rewarding types of continuing professional development: self-audit. The authors summarize arguments that lectures and other “traditional” continuing-education methods do not lead effectively to changes in practice; they provide the rationale for Maincert’s attribution of “double points” toward accreditation for time spent in self-audit; and they describe how to perform an audit of a part of one’s clinical practice. The simplicity of their approach makes it accessible to any surgeon with little more than a pencil and the motivation to improve her or his performance (and get double points).

Several questions arise from the authors’ report. Who will cover the human and capital resources required for yet another activity expected of practitioners? How will surgeons find the time to self-audit? Who will pro-

vide the education and other enablers such as templates like the one they provide for appendectomy? Will surgeons risk legal discovery if they document care in which adverse outcomes were associated with variances in the processes of care? Can surgeons and other clinicians be motivated to practise self-audit regularly? Lastly and most importantly, will self-audit make us better surgeons?

The authors begin to answer some of these queries, but full discussion of all of them would warrant a separate article. Before considering issues of resources and motivation, we need assurance that improvement of quality through self-measurement and incremental practice changes improves the outcomes of care. Data to support that contention have grown considerably in the last decade, from specific types of practice improvements cited regularly in journals dedicated to health care improvement² to larger-scale efforts, such as work in the US Veterans Administration system,³ cited in clinical journals. Based

Division of General Surgery, St. Michael’s Hospital, and Department of Surgery, University of Toronto, Toronto, Ont.

Accepted for publication Nov. 15, 2004

Correspondence to: Dr. John M.A. Bohnen, Division of General Surgery, St. Michael’s Hospital, 30 Bond St., Toronto ON M5B 1W8; fax 416 864-3049; bohenj@smh.toronto.on.ca

on such expanding evidence, payers and regulatory agencies, including the Royal College of Physicians and Surgeons of Canada (RCPS), have growing expectations that we teach and practise quality improvement. Provincial licensing bodies have moved substantially from disciplinary actions to remediation by practice enhancement in cases of breaches of practice standards that do not involve immoral or unethical behaviours.

Measuring processes and outcomes and testing strategies to enhance clinical care must become ingrained in our work as clinicians. To overcome barriers to self-audit, health care leaders must build the capacity for improvement into organizational structures and processes. To that end, the RCPS is prodding us in the right direction by insisting that training programs teach quality improvement and by encouraging clinicians to practise self-audit. We must make a choice, now: to start learning by doing (as we have done countless times, with operative procedures) or wait for forcing legislation or regulations. We will serve the interests of our patients and ourselves by heeding the call of our colleges, starting with the methods of Birch and associates.¹

Resource allocations to support self-audit must be made at the hospital level, where surgeons ply their trade. Hospital risk managers and physician leaders must develop com-

mittees or other organizational structures to facilitate compliance with recent legislation (such as Ontario's Bill 31) that allows clinical audits to avoid legal discovery. In academic centres, the involvement of house staff in clinical audits and improvement projects must be deemed a valid type of scholarly creative professional activity, and serve as fodder for academic promotion. Funding agencies must support research in methods in clinical audit more strongly, and acknowledge that the statistical paradigm that has been applied to randomized controlled clinical trials does not apply necessarily to improvement methodology.⁴

Birch and coauthors¹ see a role for professional societies in developing templates for practice audits. I support that view, which would build on the existing work of regional and international societies dedicated to particular medical conditions that afflict patients. Specialty societies bring together already a cross-section of practitioners to debate care processes and develop practice guidelines, a natural starting point for individual practice assessments.

Surgeons themselves must recognize that they can build capacity for audit within their own practices by starting small and applying lessons such as those provided by Birch's group.¹ Once a surgeon receives feedback about her or his own practice, the natural inclination to improve

kicks in. In my own practice, as a result of 2 small audits that took little effort, I have improved wait times for clinic appointments, and patient satisfaction after outpatient operations.

Most of us accept that *someone* should monitor our results, but believe it is beyond our capacity to do so. We must work against that mindset in ourselves and the practice communities we work in. If we deny our own role in self-reflection, measurement and improvement, we will abdicate this critical component of patient care to bean-counters and regulators.

Competing interests: None declared.

References

1. Birch DW, Goldsmith CH, Tandan V. Users' guide to the surgical literature: self-audit and practice appraisal for surgeons. *Can J Surg* 2005;48:57-62.
2. Andrs K, Brooks JW, Savage L, Cohen NM. Performance improvement with a multidisciplinary clinical guideline for patients undergoing minimally invasive thoracic surgery. *Jt Comm J Qual Saf* 2004; 30:89-94.
3. Khuri SF, Daley J, Henderson WG. The comparative assessment and improvement of quality of surgical care in the Department of Veterans Affairs. *Arch Surg* 2002; 137:20-7.
4. Benneyan JC, Lloyd RC, Plsek PE. Statistical process control as a tool for research and healthcare improvement [review]. *Qual Saf Health Care* 2003;12:458-64.