A tool for practice evaluation and improvement

Therapists are interested in audit
A growing number of calls to the RCCM’s information service are from practitioners wanting to find out more about audit and complementary medicine. It is evident that there is confusion about what audit can and cannot do. Audit is a tool, with an evaluation component, that can help us look systematically at the quality of the care provided to patients. Most importantly, it can help identify the need for change in practice and develop strategies to implement change. This commitment to change is key. Because its main aim is to improve quality, audit is far removed from controlled or uncontrolled clinical research. It can not prove the effectiveness of a therapy. The RCCM believes that audit should be an integral part of all health care.

The three phases of an audit cycle.
Audit is a framework for reviewing, assessing and improving day-to-day practice. At its very simplest, it takes the form shown in the figure below. This shows the three key stages of all audits: collection of data on performance, assessment of that performance against criteria of good practice and action taken if there is a need for change. Audit is cyclical. Ideally the stages are repeated as knowledge about good practice develops.

It is sometimes thought that audit is mainly about data collection and analysis. This is a misconception. Take the example of an osteopath who wants to look at referrals from local general practitioners. The collection and analysis of information - for example, who is referring, what for and how often - is only one part of the osteopath’s task.
Equally important are the decisions and actions that follow this analysis. For example, once it is known what is going on, what can be done that might improve the referral process? The osteopath might develop a standard referral form on the basis of their findings. This will also need to be trialled to see if it serves its purpose. Does the form lead to fewer inappropriate referrals?

**Relationship between research and audit.**

Decisions about clinical care need to be based upon rigorously collected information. But audit is more about managing change than it is about finding out new knowledge. More important is a willingness to critically examine one's own work and take action if it is needed. This ideal of reflective practice is not new to the complementary therapy professions.

**Audit cannot be used to prove therapy effectiveness.**

Practitioners often think that they can collect data on the health of their patients and use audit to investigate whether or not their therapy works. But audit is a very poor way of answering this question. Reliable evidence on effectiveness is best provided by clinical trials. In contrast, audit is based on observation and answers a different type of question altogether. Audit asks, "am I doing what I should be doing?" and then "have these changes to my practice made me more able to do what I should be doing?". Audit depends upon existing knowledge: knowledge of what is effective; of what is considered good practice; of what benefits patients. It supplements effectiveness research. It is generally agreed that the first step is to find out what is effective. Only then can we use audit to help make sure this is being done.

One often-quoted example from general practice is the use of audit in the care of people identified as being at a high risk of developing diabetes. Simple blood sugar check-ups have been shown to reduce the risk of full-blown diabetes and yet many general practices do not routinely check their high risk patients. A survey might identify what proportion of patients are being seen. Details of the patients at high risk could be used to develop a prompting system that identifies them and calls them in for testing. A follow-up survey would then check to see if a more acceptable proportion of patients was being screened.

**What can be audited in complementary medicine?**

We do not yet have a great deal of evidence from clinical trials for the effectiveness of different complementary therapy approaches. However audit is carried out in many areas of health care where research is sparse. Audit advisors to the orthodox medical profession recognise that individual practitioners and professional bodies have their own, valid ideas of good practice and that audit of these can be useful.

For the present time, audit in complementary medicine is possibly best focused on basic aspects of good patient care. For example, how many complementary therapists feel confident that their case note taking could not possibly be improved? One recent survey of 18 traditional Chinese medicine practices reports a wide variation in record-keeping (Wadlow & Peringer, 1996). While
98% of case notes recorded the age of the patient, only 35% recorded the outcome of treatment and 39% did not record a TCM diagnosis.

Very few published surveys have systematically examined complementary therapy practice in the UK. Only a handful of practice-based studies have been carried out, most of these being centred around referrals within the NHS. As a result, practitioners of traditional Chinese medicine are probably amongst the best informed about their profession’s clinical activities. Most therapists simply do not know what happens in their colleagues’ consultations. Most will not have systematically investigated their own. The potential of audit to help develop standards in basic areas such as record keeping would appear to be a pressing consideration for the complementary therapy professions.


Quality initiatives: what is happening in complementary medicine?

Note: A version of this paper was first published in: Research and Information in Complementary Medicine, October 1996 33:14-17. While true audit studies in CM appear to be scarce, there is some evidence that complementary practitioners have begun to look systematically at the care they provide for patients. The bibliography in this pack aims to be a comprehensive list of published studies in this area. In the meantime, a number of complementary medicine bodies are investigating the potential of evaluation methods and several projects are ongoing.

Audit and other quality initiatives in CM

The establishment of an audit department for the chiropractic profession in the UK. This is a joint venture between the Anglo-European College of Chiropractic and the British Chiropractic Association. International guidelines on chiropractic standards of care were reviewed in the UK in 1993. Two audit packages, for chronic back pain and for neck pain, have been developed. Chiropractors nationally are being asked to audit case notes to see how these compare with agreed standards of care. Students at the AECC are required to complete an audit project as part of their postgraduate year.

An examination of the appropriateness of treatment and case history taking at the British School of Osteopathy’s Clinic at St Martins in the Field.
The study of the clinic, which is for homeless people, included an analysis of case notes for the frequency of conditions seen and interviews with practitioners and patients. This resulted in suggestions for redesign of the case history sheet.

An audit of case note taking at the Complementary Therapies Centre of the Lewisham Hospital NHS Trust.

An initial survey identified variations in record keeping between the clinic's six independent complementary therapy practitioners. Professional and NHS guidelines were reviewed and a set of standards were agreed. Planned audits include an investigation into GP requirements on discharge.

The Royal London Homoeopathic Hospital NHS Trust has a full time audit co-ordinator. The Hospital uses a number of outcome questionnaires in its clinics and holds regular audit and communication meetings. The hospital has a separate Quality department that evaluates the hospital's standards in non-clinical areas. The Faculty of Homoeopathy has produced a consensus document of clinical standards (UK Faculty of Homoeopathy, 1995).

The Foundation For Traditional Acupuncture has organised workshops on audit and is involved with the British Council for Acupuncture in investigating this subject for the acupuncture profession.

The Education Department of the General Council and Register of Osteopaths has produced a guide to audit (Collins, 1994). This was distributed to all members of the profession in 1994.

A set of quality standards and model for auditing homoeopathic practice have been produced by students from the College of Homoeopathy, Regents Park (Pay & Stone, 1996).

The European Scientific Cooperative on Phytotherapy (ESCOP), an umbrella organisation that aims to advance the scientific status of phytomedicines has developed a set of Europe-wide standards for herbal medicine practice.

Practitioners are advised to contact their professional body to find out if they hold or publish any guidelines, protocols or recognised standards. These can then be used as a starting point for audit. Ask what steps your professional body is taking to investigate the potential of audit and other forms of practice evaluation for its members. The RCCM continues to collect information on audit and other research-based quality initiatives in complementary medicine (published and unpublished) and is interested to hear from those that have completed or are planning such work.

Audit: an introduction to methods
There is nothing new about the methods used within audit. Most audits are based upon reviews of written or electronically stored material (patient records, clinic attendance sheets), on observation, questionnaire-based surveys or interviews. Several text books cover these well (Irvine & Irvine, 1991; Crombie et al, 1993).

These research methods need to be used as carefully as they would be at any other time. For example, if you are interested in patient case notes, how are you going to select these to minimize the possibility of sampling bias? Have you pretested any questionnaire or data sheets you plan to use so as to check them for clarity and ease of analysis? Most importantly, are your chosen methods actually going to provide the answers you need? It helps to draw up a protocol that details your audit question and a step by step description of your plan of action. You can show this to others for methodological advice. It can also help to encourage others in your clinic to get involved.

Two hypothetical audits are outlined below. These projects share a number of stages (modified from Pay & Stone, 1993):

1. Identify and agree with colleagues on the focus and question(s) of your audit
2. Consider, and possibly set, standards
3. Identify appropriate sources of data
4. Decide on the most appropriate methods of data collection
5. Collect data by the most simple, practical and appropriate methods
6. Spot-test the validity of your data (look at another data source)
7. Process the data into a form that can be analysed (summary data sheets)
8. Analyse data and identify strengths and weaknesses
9. Present these results to colleagues
10. Review desired standards (is best practice being applied locally?)
11. Identify and agree on ways to make changes to practice (including a timetable for change)
12. Review changes after the allotted time
13. Acknowledge improvements made so far
14. Decide when it is appropriate to review the issue

Background

The two examples below have been selected to illustrate the cyclical nature of audit. Neither the topics or the standards set should be seen as prescriptive. Since every clinic has its own problems, priorities and environment, no two audit projects will be the same. Again, readers are advised to read completed audit projects and consult with others in their profession. They can then select the topics and methods of assessing quality that they consider to be the most appropriate for their own circumstances. For those new to audit, a project that aims to improve the quality of case notes would seem to be a good place to start. If only because many other audits depend on the use of those case notes.
Example 1:
A hypothetical outcomes audit in general practice

- Background: At an audit meeting of the practice, a GP and her colleagues decide that they want to improve their care of young hypertension patients. Recent research suggests that it is possible to achieve a reduction of blood pressure to 90mm Hg within the first year of treatment of a new hypertension patient aged 20-35. The clinic decides that this should be a target for 80% of their hypertension patients.
- Standard: that 80% of hypertension patients aged 20-35 should have a blood pressure level less than 90 mmHg within the first year of treatment.
- Method:
  retrospective analysis of patient notes, recording age and blood pressure level
- Initial results: only 60% of patients fall below the specified blood pressure level.
- Next audit meeting: the clinic team decides to instigate a more detailed study of their treatment of young hypertensives. They find that a significant number are receiving dietary advice as late as six months after their initial diagnosis. A protocol for hypertension patients is written through consultation with the dietician attached to the clinic.
- Completing the audit cycle: the same analysis is repeated six months on, finding a rise to 90%.

Example 2:
A hypothetical process audit in a complementary therapy clinic

- Background. A complementary therapy clinic receives funding for GP referrals. The funding is dependant on the clinic providing details of its audit work to the local Health Authority. An initial survey of patient notes shows that the clinic's six therapists have very different ways of describing their consultations. The practice manager is unable to use the notes to provide details of the clinic's work for his Health Authority report. He is also concerned about legal requirements for these notes. At a clinic meeting he describes the minimum legal requirements for case notes. The therapists agree that they would also like to have a summary sheet attached to each set of notes. This would contain details of age, sex, presenting conditions and referring physician and space for a summary of each consultation. The meeting agrees on standards and an audit cycle.

- Standard 1): 100% of the record cards of 'active' patients must be written in English, must be dated and signed.
- Standard 2): 80% of the notes of 'active' patients should contain a summary sheet
- Standard 3): 60% of summary sheets should detail age, sex, presenting conditions, referring physician and a summary of each consultation.
- Method: Development of summary sheet. Retrospective analysis of notes four months after meeting.
Initial results: 95% of cards sampled fulfill standard 1; 95% of sampled notes fulfill standard 2; 30% of summary sheets fulfill standard 3.

Next audit meeting: one therapist points out that they do not have enough clinic time to complete the summary sheet. There is discussion about which aspects of the summaries are most useful for referral within the clinic. It is decided that the therapists be allowed extra paid time to summarise their case notes for each session. The group decides to continue with these standards and analyse case notes again in three months.

Completing the audit cycle: three months on, 50% of summary sheets are complete. One of the therapists presents a review of the patients seen over the previous six months. The group decides to obtain research papers to investigate the effectiveness of their therapies for the conditions they are seeing. They decide to continue through another audit cycle.

**Evaluation of complementary medicine in practice: some working definitions**

**Background**

Studies that evaluate complementary medicine in practice take several forms. The terms that describe the different methods are often used loosely. When you see one being used it often helps to question what the author or speaker means. The definitions provided below have been taken from a selection of recent textbooks and reviews for health professionals.

Clinical audit is a term that has been in common use among health professionals in the UK since the late 1980s. Clinical audit is broadly understood to be a tool, with an evaluation component, that can help us look systematically at the quality of the care provided to patients. Most importantly, it can help change that practice if it is decided that change is needed. In the 1996 NHS Executive document, 'Promoting Clinical Effectiveness', audit is described as a "professionally-led initiative which seeks to improve the quality and outcome of patient care through clinicians examining their practices and results and modifying practice where indicated". It is also described as being able to "provide assurance about the quality of patient care". Explicit standards are central to audit: before we can examine whether something is of a good enough quality, we have to decide what 'good enough' is.

**Exploratory or pilot audits.**

This term is sometimes used to describe surveys of practice that are carried out with the aim of improving effectiveness or efficiency but do not detail changes in that practice. Such studies are sometimes also known as 'practice activity analyses' because they look at the activities of a specific clinic or group of practitioners. They may examine, for example, patient demographics, patterns in presenting complaints, prescribing or referral behaviour. Sometimes, these studies
develop into full audits. A practice activity analysis might show that the waiting times of certain groups of patients are unacceptably long. On this basis, a clinic then might decide to modify its appointment system and write up guidelines for referral within the practice. If waiting times are surveyed again, following these changes, the audit cycle has been completed. Since we have so little research evidence as to what actually goes on in complementary medicine clinics, these studies are extremely valuable sources of information for future audit and research.

Quality of health care.

Quality in health care means different things to different people. It needs to reflect the different expectations and values of various groups in society. Care is frequently looked at in terms of structure, process and outcomes (see below). Another frequently cited approach was proposed by Maxwell. (Maxwell 1984). He suggests that the quality of care has six components: its relevance to the individual or population; its accessibility; its effectiveness in achieving benefit for the individual or population; its acceptability, within reason, to patients and the community; its efficiency in using resources and the equity of its distribution.

Quality assurance is broadly defined to mean all activities that are designed to improve the quality of care. This includes audit, but also the development and use of standards, clinical guidelines and protocols. Quality assurance is sometimes used within the NHS to describe quality initiatives that do not directly involve health professionals, eg improvements to the built hospital environment.

Standards have been described as a professionally agreed expression of optimum practice. Various complementary therapy professions are examining practice standards. The Faculty of Homoeopathy, for example, has published a set of “Proposed minimum standards” (UK Faculty of Homoeopathy, 1995). These include explicit recommendations for homoeopathic doctors on required training and experience, referral, waiting times, consultation procedure, consultation environment and use of audit. One specific standard, for example, is that communication with a referring doctor should take place within 10 working days. Standards, both of minimally accepted and good practice, are central to audit. They are sometimes agreed upon at the beginning of an audit cycle, sometimes they arise and develop during evaluation of practice. The important thing is that the audit process requires and encourages them to be made explicit.

The structure of care refers to organisational factors that determine the conditions under which care is given, eg the physical environment, staffing levels.

The process of care refers to the interactions, transactions and activities involved in providing care for a patient. For example, a hospital-based process audit might compare its care against an agreed standard that 75% of patients attending its out-patient clinic who score between 1-3 on an arthritis assessment questionnaire should have received occupational therapy within the previous 12 months. This form of evaluation follows from the argument that if a certain procedure
is known to be effective, demonstration that the procedure is being undertaken helps to assure
us of the effectiveness of care.

The outcome of care is a measure of patient health and well-being following treatment. Standard
setting for patient outcomes is more problematic: a target that is appropriate for an inner city
clinic may be inappropriate for a rural practice. Outcomes in a clinic may be monitored before
they are audited against explicit standards. Outcomes may also be collected to inform future
research work (eg. Reilly et al, 1996).

Programme evaluations are usually carried out to find out whether improvements in patient
health warrant the time and effort spent on them. They are usually carried out to satisfy a funding
body and the objectives of these studies will frequently be set by the funding body. The provision
of CM in the UK has often come about through ‘innovative practice’ projects, where a clinic is
funded on the understanding that an evaluation report will be produced to inform further policy.
Funding bodies may ask for descriptive details of the service they have paid for (details of the
structure and process of patient care). They may also request information on outcomes, which
might include, for example, clinical measures, cost estimations and measures of patient
satisfaction. Evaluation projects are often characterised by their use of multiple research
questions.

Outcomes research is research that looks at the impact of services on the health and well-being
of patients “in the real world”. It is a term relatively new to the UK but in common usage in the
US. Its use in the US is worth examining in some detail simply because developments in health
care evaluation in the States are often incorporated into practice in the UK. The purpose of
outcomes research has been defined as “linking the type of care received by a variety of patients
with a particular condition to positive and negative outcomes to identify what works best for which
patients. The link ... is assessed within the everyday practice of medicine rather than under
controlled conditions, as in clinical trials of therapeutic efficacy.” (Guadagnoli & McNeil, 1994).
Data are usually collected using observational methods. This approach differs from the rather
artificial situation of the randomized controlled trial. In the US, outcomes research is also used
more broadly to mean the collection and reporting of data that is then used to compare the
quality of care between providers (see quality assurance). This data can include indicators of
care, such as immunisation rates or the degree of adherence to guidelines or protocols. In the
US, outcomes research may be used solely within a hospital or clinic, but it is often
commissioned and used by purchasers to monitor services. Outcomes research is still in its
infancy. The validity of the information it produces is often questionable: for example, how
comparable are the patients seen in two different out patient clinics? what measures should be
used to monitor outcomes? Its methods, however, are used increasingly by providers,
purchasers, insurers and patient groups, both in the US and the UK. Guadagnoli and McNeil note
that its use may be less problematic in some areas of health care (for example for quality improvement within a hospital) than in others.

Clinical guidelines are appraisals of good practice written and distributed among clinicians with the aim of improving patient care. They are used increasingly within the NHS in the UK. The degree to which they are based upon research evidence (“evidence-based”) varies, as does the type of consensus reached during their compilation. One recent guideline development project (Eccles et al, 1996), used a mixture of a semi-systematic review of clinical trials and expert opinion to produce guidelines for general practice management of asthma in adults. A variety of health care professionals and patient groups were represented on the project.

Searching for evaluation studies in complementary medicine

Background
A literature review can often help a researcher to define a study topic, identify appropriate research designs and avoid the mistakes of previous workers. With the current state of the literature, however, searches on the subject of audit and the evaluation of care in complementary medicine are difficult to carry out. There are a number of points worth bearing in mind.

- Read studies from a variety of health professions.
  It is early days for the systematic evaluation of care in complementary medicine. Audit in particular is a relatively new concept for many complementary therapy practitioners. High quality published papers are scarce. Practitioners may find studies from professions that are more used to the terminology and methods of practice evaluation useful. Several excellent text books and work books exist (eg. Irvine & Irvine, 1991; Crombie et al, 1993; Collins, 1994; Chartered Society of Physiotherapists, 1994). Good sources for published audit and quality assurance work include 'The British Journal of General Practice', 'The Journal of Evaluation in Clinical Practice', 'Quality in Health Care' and 'Audit Trends'.

- What is your question?
  Think about the type of question you are interested in. This should direct you to the most appropriate methods. For example, you may be hoping that audit studies will tell you something about therapy effectiveness. However, audit does not examine effectiveness directly. Instead, it examines whether steps known to be effective are being taken. Likewise, researchers interested primarily in methods used to improve the quality of care may want to broaden their search beyond audit, to include studies that look at practice standards, guidelines and other methods of encouraging change. In short, a variety of methods can be used to evaluate and improve
complementary medicine in practice. These are outlined in the accompanying sheet, 'Evaluation of complementary medicine in practice: some working definitions'.

- Audit studies and programme evaluations tend to remain unpublished. Journal editors may judge that audit findings are too localised to be of general interest. Examples of complete audit projects are worth reading, if only for an understanding of the issues that can arise. Furthermore, published audit papers often contain details of practice standards or guidelines, developed during the course of audit work. These standards and guidelines may then be modified for use in other contexts. A number of sources of audit work are listed in the bibliography. Project evaluations are also difficult to find. They are often considered the property of the project's funding body and are only available on request from that body.

- The term 'audit' in particular is often applied very loosely. The RCCM has identified a number of published papers that use the word audit in their titles. The majority of these, however, are perhaps classified more appropriately as surveys of practice, uncontrolled clinical trials or programme evaluations. The authors of these papers may indeed be carrying out audit. Their papers, however, do not show an explicit link between the evaluation of practice to change in that practice. To see if an audit programme is being described ask the following question: does this paper describe both an evaluation of practice and the steps taken to improve practice based on that evaluation.

- Evaluation projects and audits need to be read with a critical eye. These types of study will not always have been appropriately peer reviewed. You will need to appraise the validity and reliability of their methods and findings with extra care. Start by asking the following questions: are the study's methods adequately described? are they appropriate for the question in hand? were appropriate statistics used? are the results clearly presented? were the conclusions of the study justified? If the study claims to be an audit, does it discuss change in practice? Refer to recent text books on audit and evaluation methods for further help in critical appraisal (see bibliography).

The RCCM's Information service welcomes comments on this pack. Let us know if you are aware of other published work in the field of evaluating and improving complementary medicine in practice. Also plan to publish so that your work appears in print to inform others. Try to take account of the time and effort required to produce publishable material when carrying out initial costings for any research project.

References
The categories of study used below are for guidance only and should not be taken to be definitive. Readers are advised to read the guidelines, 'searching for published audit work in complementary medicine', provided in this pack, before using these references.

**Literature Reviews/ Critiques of Methodology**


Collins M, A guide to audit in osteopathic practice & A workbook on audit for osteopaths Volume 2 of 'Your osteopathy: getting your professional message across'. Nov 1994. Education Department, The General Council and Register of Osteopaths


Outcomes research is a broad term. It involves not only investigations of the link between medical care and outcomes, but also activities aimed at assessing quality of care. The number of individuals and organisations involved in outcomes research has grown rapidly over the past decade. Despite this activity, some observers question whether outcomes research can deliver on its promises. In this paper, we define the scope of outcomes research and then discuss its potential for fulfilling the expectations of various stakeholders who have played a role in its design and implementation.


RCCM comment: The author outlines his belief that the potential for audit in health care has been diluted by confusion over its role. "Simple methods sufficient to improve care in a local and low key way have been confused with the much more rigorous methods required to monitor contract performance and to begin to compare the performance of different hospital teams".


There is an increasing demand for complementary medicine. This paper reviews some of the audits that have been used within this area of medicine and suggests a strategic approach to the development of complementary medical audit within the National Health Service. It is hoped that this will allow purchasers and practitioners of complementary medicine to determine the
effectiveness and cost-benefits of these therapies, at the same time as improving standards of practice.

NHS Executive, Promoting Clinical Effectiveness: a framework for action in and through the NHS Aug 1996 (13) NHS Executive, UK


RCCM comment: Literature based study examining relevance of audit to homoeopathic practice in UK. The authors propose a detailed set of quality standards for care. These were discussed and refined in a practitioner forum. At the time of writing, a pilot audit using the proposed model is planned for a South London clinic.

Reference texts
Kogan M, Redfern S Making Use of Clinical Audit 1995 Open University Press, Buckingham Papers that describe the use of audit as a means of improving the quality of care.

References from the CISCOM database

Papers that describe the use of audit as a means of improving the quality of care in CM.
RCCM comment: A survey of referral practice identified a high level of inappropriate referral. A referral protocol was developed, along with a proforma for patient notes containing a check list of contra-indications for acupuncture treatment and prompts calling for diagnosis and reason for referral.
Peters D, Davies P.
Changes in the management of back pain in general practice resulting from GP access to osteopathy: executive summary.
South & West RHA report of workshop on Research and Development in Complementary Medicine, 12 July 1994, Winchester, UK.
RCCM comment: Summaries of the numbers of patients seen, diagnoses, treatments and changes in patient conditions were presented at regular multidisciplinary meetings of practitioners at London's Marylebone Clinic. The authors claim that these 'rapid audit cycles' promote communication and reduce inappropriate referrals.

Other papers that describe quality assurance initiatives in complementary medicine

Allen CE
An analysis of the pragmatic consequences of holism for nursing
West J Nurs Res 1991 Apr;13(2):256-72

Anonymous CCE approves changes in 'Standards'
J Chiropractic 1989 May;26(5):63-5

Anonymous
The search for the efficient practice Am Chiropractor 1991
Aug;13(8):43-4

Anonymous
Commentary: Reliable standards of care are determined by consensus of those who provide that care

Anonymous
The ACA provides testimony at the public meeting on clinical practice guidelines for low-back problems
J Chiropractic 1992 Nov;29(11):34-45

Anonymous
C.A.R.E. "shakes up" chiropractic malpractice insurers

Anonymous
BMA's about-turn has wide-ranging implications for hypnotherapy

Despite major technological advances in the treatment of cancer, many patients are dissatisfied with conventional biomedical interventions. This is largely because they fail to resolve long term intractable problems such as chronic pain or stress. More emphasis is now being placed on quality of life. This shift in attitude has opened the door for complementary therapies as adjuvants to traditional models of cancer care. Changes within the NHS have facilitated this transition, by the creation of the 'internal market' and the development of central funding to individual clinical directorates. To exploit these opportunities, complementary, therapists must develop new skills and be prepared to adopt NHS standards of assessment to evaluate the efficacy of their work. Standards are a component of 'Quality assurance'. They are observable,
achievable and measurable, and contribute towards an acceptable evaluation process.
Standards are used by health care purchasers to assess which therapies should be made
available to patients within the NHS. This paper describes the development of a massage service
that has been integrated into the Hammersmith Oncology Department. The massage standard is
seen to be fundamental and essential to the continued development and evaluation of the
project.

Carey PF
A suggested protocol for the examination and treatment of the cervical spine: managing the risk J
The purpose of this article is to review what is generally acceptable and recommended for the
examination and treatment of the cervical spine, particularly when considering the risks of
vertebrobasilar accidents.

Chapman-Smith DA, Mior SA
In recent years guidelines for chiropractic parameters of care have been developed in Canada
and the United States. One of the principal reasons for developing such guidelines was to protect
the best interests of the patient. However, in order for guidelines to be accepted by the
profession and the public at large, they must be constructed using appropriate consensus
methods and the recommendations made should be evidence based, reflecting the current state
of clinical practice. If constructed in this manner, the guidelines become defensible and may be
used to support decisions made in patient management.

1996 Sep;10(5):1-5.

Clark CC, Cross JR, Deane DM, Lowry LW Spirituality: integral to quality care Holistic Nurs Pract
1991 Apr;5(3):67-76

Cohen M Eastern and Western medicine: complementary in practice, equal in status Am J
Acupunct 1992;20(2):137-42

Donahue J. Competency-based professional standards: a fundamental consideration [letter].
Journal of Manipulative & Physiological Therapeutics. 1994;17(2):131-2,

Ebrall PS A chiropractic screening health questionnaire: a pilot study concerned with quality

Ersser SJ Complementary therapies and nursing research: issues and practicalities Complement
Ther Nurs Midwifery 1995 Apr;1(2):44-50
This paper explores the issues which nurses face in attempting to use research-based literature
and when conducting research in the field of complementary therapies. Despite the significant
interest among nurses in using such therapies, there can be difficulties in gaining access to such literature and using it to inform practice. Rising standards of accountability create expectations for nurses to draw on sources of information which inform safe and effective practice. The issue is examined and illustrated by looking at the example of nurses use of essential oils. Strategies are explored to help nurses to practice in an informed way and to engage in research activity in this area. This article is based on a paper given at the Research Council for Complementary Medicine Conference "Research from Concept to Publication" at the Royal Society of Medicine, London 1993.

Fisher P
Improving homoeopathic practice
Br Homoeopath J 1993 Apr;82(2):81-2

Fitter M, MacPherson H

Freedman A
Standard of care
J Can Chiropractic Assoc 1991 Dec;35(4):229-31

Freeman LH, Mornhinweg GC
Standards of practice by Nightingale
J Holistic Nurs 1992 Dec;10(4):348-54

Fritz HG.

Gatterman MI Standards of practice relative to complications of contraindications to spinal manipulative therapy J Can Chiropractic Assoc 1991 Dec;35(4):232-6

Gilkey DP
Standard treatment protocols and quality assurance: where will they lead?
J Chiropractic 1994 Mar;31(3):35-7

Gilmore DA
The antitrust implications of boycotts by health care professionals: professional standards, professional ethics and the first amendment
Girimaji P
Voluntary scheme for certifying quality of health services
Hahnemann Homoeopath Sand 1995 Sep;19(9):19-20

Gitelman R
Clinical guidelines for chiropractic practice in Canada: using guidelines to enhance patient management

Hansen DT
Current efforts in chiropractic quality assurance and standards of care

Hansen DT
Back to basics: determining how much care to give and reporting patient progress
This article addresses the concept of defining thresholds of care relative to patient-centered management, and how the patient's progress can be reported in a doctor's chart and to other interested parties. The changing elements of health care delivery require that standards be applied in the reporting of patient progress and justification of care. Hansen DT

Prospects for the future of chiropractic guidelines
Advances Chiropractic 1995;1:417-54

Hansen DT, Adams AH, Meeker WC, Phillips RB

Hansen DT, Mootz RD
Understanding, developing, and utilizing clinical algorithms
Top Clin Chiropractic 1994 Dec;1(4):44-57
This article reviews clinical algorithms and offers hints on how to understand them better. It also provides some initial instruction on how to develop these tools and how to evaluate and critique them for content, clarity, flow, and appearance. A brief introduction to small group consensus methods is also provided as well as guidance for small study groups and local organizations to adapt existing clinical algorithms into applications for quality improvement within a doctor's office or group practice setting.

Hansen DT, Mootz RD
Formal processes in health care technology assessment: a primer for the chiropractic profession
Top Clin Chiropractic 1996 Mar;3(1):71-83
As chiropractic finds increasing public acceptance in health services and reimbursement, a commensurate increase in requirements for proper assessment of chiropractic technologies and
procedures, along with documentation of appropriate guidelines for care, is occurring. This article reviews the nature of technology assessment (TA) and examines how TA is affecting individual DCs and the profession as a whole. A qualitative review of selected, relevant TA literature was performed. Background information about recognized organizations addressing technology assessment issues was gathered. From this process, an overview was synthesized regarding issues confronting the chiropractic profession. Academic, scientific, clinical, and political leaders in the profession acknowledge the need for appropriate methods of technology assessment and guideline development. There is some evidence of advancing efforts in proper assessment of technologies found in chiropractic practices. A trend towards patient-centered values in health delivery is stimulating some changes in formal technology assessment sequences. It is recommended that the knowledge in individual practitioners regarding TA processes be enhanced and that more and different constituencies take responsibility for advancing that knowledge.

Hayes OW
Clinical practice guidelines: a review
J Am Osteopath Assoc 1994 Sep;94(9):732-8

Henderson DJ
Towards the development of guidelines on chiropractic care and practice: an opportunity to enhance professional credibility

Hinkley H, Drysdale I.
RCCM comment: Exploratory survey of patient age, sex, presenting condition. Suggests a number of potential uses including feedback to college administrators so that they can target certain age groups and conditions. Jamison JR Competency-based professional standards: a fund-amental consideration
J Manipulative Physiol Ther 1993 Sep;16(7):498-504

Jansen C.
[Patient education regarding the suitability of medical practices, hospitals and alternative treatment methods--from the legal viewpoint]. [German] Zeits. fur Arztliche Fortbildung.1994;88(12):1027-31

Kanjilal JN How a Neophyte in homoeopathy can advance in the art of prescribing in the Hahnemannian line to become a successful practitioner Homoeopath Heritage 1995 Oct;20(10):667-74

Kleynhans AM The establishment of competency-based professional standards for chiropractors Chiropractic J Aust 1992 Sep;22(3):98-104

Koss RW Quality assurance monitoring of osteopathic manipulative treatment J Am Osteopath Assoc 1990 May;90(5):427-34


Lentin B Doctor and patients under the Consumer Protection Act Hahnemann Homoeopath Sand 1994 May;18(5):11-5


The use of complementary therapies is rapidly growing in popularity, but there are few guidelines as to what constitutes acceptable standards of training when using these therapies within orthodox health-care settings. This article explores some of the issues facing therapists who wish to make complementary therapies more readily available to their patients.

Maurer EL Seeking professionalism J Chiropractic 1993 May;30(5):75-8

McClain CL The AHCPR guidelines: are they all that they seem? J Am Chiropractic Assoc 1995 Feb;32(2):43-6

There is momentum in the health care industry to move toward purchasing health services in managed care settings. This article provides background information regarding trends of recent industry changes, how the health disciplines are responding, and how chiropractors can fit into this evolving system.

McMichael RA, Poortinga G, Powell J, Sheely RB, Poteete RD, Sherman R
Reliable standards of care are determined by consensus of those who provide that care J Manip Physiol Ther 1991 Mar-Apr;14(3):217-21

Meeker WC The future impact of clinical practice guidelines
J Manipulative Physiol Ther 1995 Nov-Dec;18(9):606-10
Clinical guidelines are a very hot topic. Many guidelines are being published, but many concerns about guidelines still exist. Guidelines may be able to increase the quality of health care while eliminating unnecessary or inappropriate care. Critics wonder if the process will instead lead to poorer care and a waste of time and effort. Although guidelines are targeted on providers of care, those with other roles will use guidelines for optimizing patient care and outcomes, assuring quality, cutting costs and tracking liability and risk management. Examination of guidelines and their impact suggests that the process and product are imperfect and that the impact is difficult to measure. The chiropractic professional will continue in its guideline efforts. The direct effects of guidelines will be on certain aspects of doctor knowledge, attitude, belief and behavior. The indirect effects will be largely attitudinal in nature at first but will eventually lead to action. The profession will embrace the need to (a) develop a more comprehensive and useful research database and (b) to develop sophisticated means for obtaining profession-wide consensus on fundamental clinical issues.

Melchart D, Linde K, Miller R, Polonius D
Qualitätssicherungs-Vorhaben "Naturheilverfahren" im Rahmen des Klinik-Verbunde "Munchener Modell"

Melchart D, Weidenhammer W, Perkuhn K Zur Situation der ärztlichen Weiterbildung in Naturheilverfahren: Beispiele europäischer Länder und eines Qualitätssicherungs-Projektes
Forsch Komplementarmed 1995 Aug;2(4):203-10
Drawing on further training programs available in Germany, France and Spain, the paper illustrates the basic status quo of European post-graduate education in natural healing procedures. The formation of a consensus on subject matter and quality assurance for post-graduate educational programs remain important future tasks on both a national and international level. The concept of the "Munchener Modell" is outlined and is conceived to provide a new stimulus to post-graduate education of physicians in natural healing procedures. A synopsis gives learning objectives, subject matter, educational methodology and educational media.
Methodological foundations of the scientifically based quality assurance of the post-graduate program are presented.

Melchart D, Weidenhammer W, Linde K

Melchart D, Weidenhammer W, Hager S.

BACKGROUND AND OBJECTIVE: Within a scientific quality management program it is vital to assess the process-and outcome-quality of a complementary therapy offered to patients. The results of such an observational study should indicate the patient's benefit from the treatment, with emphasis on the long-term aspect. MATERIAL AND METHODS: In 1994 a total of 840 in-patients have been treated with TCM for four weeks. The patient's records consist of clinical findings, including patient's questionnaires for the assessment of health-related quality of life (admission and discharge, followed 2 and 6 months later by a postal follow-up with a response rate of about 80%). Each treatment was recorded, including adverse events. A subset of 145 patients with migraine has been investigated by criteria according to the international headache society. RESULTS: The major diagnostic groups are chronic pain syndromes, especially headache/migraine and back pain. At discharge the patients show a decrease in mean intensity of their complaints from 72 to 41 points (on a 100 mm VAS), followed by a slight increase up to 49 points 6 months after discharge. Quality of life improved mostly concerning the somatic dimension. CONCLUSION: The study method seems appropriate as a first step getting valid indicators for the patient's benefit. The results indicate that chronically ill patient's experience substantial improvement after treatment with TCM.


Montfort T

Muller-Fassbender H
Begutachtung des Bewegungsapparates

Neame R
Minimal effective data sets (MEDS): the case for standardization at the level of clinical protocols Br Homoeopath J 1991 Jan;80(1):21-5
Nelson DL
Assuring quality in the delivery of passive and active care
Top Clin Chiropractic 1994 Dec;1(4):20-9 This article provides an overview of a number of conceptual and clinical issues involved in providing care in such situations by reviewing considerations the clinician should take into account. A review of the physiology of injury is provided. Moreover, the effects of immobilization are summarized, and they provide the rationale for early remobilization. An overview of available passive care and active care modalities is presented along with a rationale for their application.

Ooi GL
Chinese medicine in Malaysia and Singapore: the business of healing
Am J Chin Med 1993;21(3-4):197-212

Osborne S
The Royal London Homoeopathic Hospital
Homoeopathy 1993 Apr;43(2):44

Pay J. Stone Y.
The development and use of clinical audit in homoeopathic practice 93pp report: School of Homoeopathy, Regent's College, London, UK
RCCM comment: literature review examining relevance of audit to homoeopathic practice in UK. A set of standards for care are proposed. A practitioner forum was established to discuss and refine these standards. At the time of writing, the audit model proposed is yet to be used in practice.

Peters DA
Measuring quality: inspection or opportunity?

Peters D, Davies P
Audit of changes in the management of back pain in general practice resulting from GP access to osteopathy: executive summary
South & West RHA report of workshop on Research and Development in Complementary Medicine, 12 July 1994, Winchester, UK. Marylebone Centre Trust 33 Queen Anne Street London W1M 9FB
RCCM comment: Summaries of the numbers of patients seen, diagnoses, treatments and changes in patient conditions were presented at regular multidisciplinary meetings of practitioners at London's Marylebone Clinic. The authors claim that these 'rapid audit cycles' promote communication and reduce inappropriate referrals.
Plawecki JA.
Holistic nursing - moving beyond a professional commitment.

Rankin-Box D Reflections in practice (Editorial)
Complement Ther Nurs Midwifery 1996 Feb;2(1):1-2

Redleaf A The CA - doctor relationship: the impact of gender
J Chiropractic 1993 Apr;30(4):35-40

Reilly D, Leckridge B, Duncan R
International Data Collection Centres for Integrative Medicine July 1996 Unpublished Report. The Academic Department Glasgow Homoeopathic Hospital, UK

Shiber S, Larson E

Standen CS

Steinecke R Informed consent

De Soriano G, Chase D An audit of blood tests to assess safety of herbal medicine in a general practice in the UK Abstract from the 2nd Annual Symposium on Complementary Health Care, Exeter, 3 December 1995

OBJECTIVE: to assess the safety of herbal medicine in GP practice. MATERIAL AND METHODS: NHS patients are reffered by the GP to an in-house herbalist who diagnoses and prescribes. The practice nurse takes blood tests at pre-treatment and at intervals of 1,2,3,and 6 months. Six-monthly testing then continues for the duration of herbal treatment. Full blood count, kidney function, and liver enzyme tests are examined and irregular values are reffered back to the physician. RESULTS: There are no significant abnormalities attributed to our herbal therapy. CONCLUSIONS: This method of using herbal therapy is safe. Further studies with a wider range of patients can highlight precise herbs which are most useful, and achieve a 'safe pharmacopoeia', transferable to similar clinical situations

Taylor JA, Lawson DM
Quality assurance in chiropractic radiology

This presentation discusses the components of a complete quality assurance program in
chiropractic radiology procedures. The program discusses documentation, darkroom procedures, image receptors, generator and control equipment, and radiographic techniques.

Thomas R
National Occupational Standards for Alternative and Complementary Therapists: your questions answered (plainly, clearly and honestly)

Thornberg A
Appraising your practice
Am Chiropractor 1990 Apr;12(4):44-5

UK Faculty of Homoeopathy
Proposed minimum standards Simile. April 1995; 5(2):2-4
This document outlines the recommended minimum acceptable standards required for homoeopathic specialist outpatient (OP) care in the NHS however provided, be it through existing or new NHS outlets, or independent private practitioners. This is based on the standards developed in the National Centre in Glasgow, and assumes that the expertise of that, or another National Centre, is readily available as back up. It has been produced by representatives of all the NHS providers of homoeopathic service in Scotland, with guidance from the Executive and Council for the UK Faculty of Homoeopathy.

van Haselen RA
Improving the efficacy of diagnosis in homoeopathy: towards a new methodology
Homoeopath Heritage 1993 Oct;18(10):621-3

van Haselen RA
Improving the efficacy of diagnosis in homoeopathy: towards a new methodology HomInt R&D Newsletter 1990;1,2:1-2

Van Haselen RA, Fisher P

Vear HJ
Standards of chiropractic practice

Vear HJ
Quality assurance: standards of care and ethical practice

Vickers A
Massage and aromatherapy: a guide for health professionals
Massage and aromatherapy have rapidly expanded and developed in recent years. There is little guidance for establishing the practice of these therapies alongside traditional methods of care. Writing especially for health professionals, the author addresses the issue by establishing the current state of research, analysing its implications and offering practical information and advice for those working in the health service. The book is written for practitioners and students of massage and aromatherapy, nurses, occupational therapists, physiotherapists, osteopaths, GPs and individuals working in mental health, AIDS and cancer care.

Wadlow, G.
Consistency, internal coherence and systematic practice - starting points on the road to artistry in Chinese medicine

Wafer, M.
Complementary therapies, particularly aromatherapy and therapeutic massage, can benefit many people by providing comfort and relaxation. It is important, however, that nurses administering these therapies are adequately trained in techniques and the selection of appropriate oils.

Welch, M, Fletcher, P, Piper, C.
RCCM comment: Describes the development of standardised methods for collecting data in school clinics. Analysis of data from two clinics suggests that one sees older patients than the other. It is pointed out that the range of conditions seen by students at the two schools may differ as a result.

Winters, FD, Zonia, S, Cook, JN, Dora, DL, Meyer, CT
Ambulatory care training standards for continuity of care in osteopathic family medicine
J Am Osteopath Assoc 1996 Apr;96(4):235-42
A total of 16 osteopathic family medicine residency programs joined with the Michigan State University-College of Osteopathic Medicine to form the Consortium for Osteopathic Graduate Medical Education Training Family Medicine Division. Standards were developed and implemented on a statewide basis for all member residency programs. Initial qualitative evaluations discovered minor as well as more substantive non-compliance after 6-mnth trial.

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