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Editorial

Evidence-based clinical audit: a long way to go

Increasingly, patients nowadays access information from the internet or the media and put forth to the doctors requests for treatments that they think are useful to their condition. On the other hand, we doctors are facing the challenge of escalating public expectations on professional accountability and hence liability. Given these background, clinical audit was introduced for more than two decades. A review article was written by Dr Chan Po Tak on "Basic concepts of evidence-based clinical audit" in this issue.

One of the key components of clinical audit is to set the so called standard, but what is the standard? Meanwhile, a group from the McMaster Medical School of Canada introduced evidence based practice in medicine in the 1980s. Evidence-based medicine (EBM) can be defined as "the conscientious, explicit and judicious use of current best evidence about the care of individual patients" (Sackett DL et al. Evidence-based medicine: how to practice and teach EBM. 2nd ed. New York: Churchill Livingstone Inc; 2000). The movement helps to enlighten and provide a solution to fill in the gap between clinical science and real practice. The initiative has laid the foundation for appraising the best available evidence so that a standard of practice can be derived and communicated within the profession in a mutually understandable and scientifically agreeable manner. I myself regard that this movement as a very good start within the medical profession in adapting to the change in social ecology in the modern world.

Nevertheless, there are quite a number of challenges for such a movement in Hong Kong. Hong Kong is a small place in which there are only about 80 dermatologists. There is currently not even one full-time academic staff in this quickly developing specialty. In order to introduce a system of clinical audit, the very first practical question is "Do we have the capacity to go through the whole process from systemic literature review, critical appraisal and all the way towards the formulation of a standard that is applicable in the local settings?" I am afraid we can only adopt the short cut, i.e. to use the standard developed by the more reputable institutions or organisations overseas. The short cut is not without its problems. For instance, checking the level of thiopurine methyl transferase (TPMT) before starting azathioprine is a standard in many of the more developed countries, however the facility is not readily available in Hong Kong. If we are going to set a standard, I would feel embarrassed to say that not checking TPMT is up to the local standard and let the rest of the world scrutinise with my mouth wide open. If we adopt the international standard, i.e. recommending checking TPMT level, and a patient develops pancytopaenia after taking the drug and makes a lawsuit against the concerned doctor, accuses him/her that he/she is not up to standard, could the defendant doctor still claim the possible escape

clause that the test is not available in Hong Kong?

The other gap for EBM practice is that there are inadequate well-conducted studies to support the use of many of the old drugs. Chan in his article quoted psoriasis to illustrate introducing an audit system in this condition that was commonly encountered in our daily practice. The available evidence in the literature would skew to the side of the new biologics and the merit of the time-honoured therapeutics like methotrexate and PUVA would quite likely be undermined not because they do not work as well, but because the studies on these modalities have not been as well conducted.

Furthermore, as a dermatologist working in the public sector, I would feel embarrassed to set a standard that we cannot meet for many other reasons. Taking psoriasis as an example again, no matter how we position biologics, the fact that biologics are not provided in the public sector would be faced by the largest service provider in Hong Kong.

Moreover, although a comprehensive and well-developed audit system and evidence-based practice can be introduced in health care delivery systems in the UK (University of Leicester is probably one of the icons in this arena) and Canada (as aforementioned McMaster Medical School is probably an icon in this arena), it may not be as easy in Hong Kong in which health care is not delivered by a "national health care system" and clinical governance of the profession (including the private sector, there are in fact more dermatologists in the private than the public sector) is not yet clearly defined. It is envisaged that it will be very difficult to introduce clinical audit in the private sector.

Therefore, perhaps, the more pragmatic approach is only to limit the audit cycle to the process of clinical encounter and management such as the completeness of documentation of the history taking or physical examination process. The challenge may be the loss of personal touch to our patients. The complaint by my patients that "the doctor is very busy engaged in typing or writing in the record but does not listen to what I say or even look at my face (or even skin)" is in fact not uncommonly heard nowadays in my daily clinical encounters. There is still a long way to go before an evidence-based practice and clinical audit can comprehensively be introduced in Hong Kong.

KM Ho
何景文

Tel: (852) 3718 6666 Fax: (852) 3718 6600