Clinical audit is a cyclical activity that includes setting standards of practice, comparing actual practice with the standards, changing practice that does not meet the standards set and looking again at actual practice [1]. The expectation is that as discrepancies are found and corrected, practice will be standardised. But clinicians, like most people, tend to resist change [2]. Changing practice is best achieved by an approach that combines two or more methods [3]. In this issue of *Age and Ageing*, Elliott and colleagues report an audit that improved the appropriate prescription of warfarin and aspirin to older hospital inpatients with atrial fibrillation (AF) [4]. Multidisciplinary educational meetings, feedback of audit data and reminders were used to change practice. This approach was more successful in increasing aspirin prescription than warfarin.

One reason for the underuse of warfarin is concern about its safety in older patients [5]. Evidence from studies of warfarin use in clinical practice published since the audit was carried out may help allay this concern [6]. But it will not be dispelled, as there still seemed to be a higher risk of minor bleeding with warfarin. This could affect compliance and has cost implications in terms of use of services by patients with this complication and the need for closer monitoring. Also, although the patients in clinical practice were older than those in randomized controlled trials, those over 80 were in the minority and these are the people most likely to be in AF and at greatest risk of stroke.

**Barriers to change**

Even where clinicians have the necessary knowledge and skills, receive feedback on performance, have clear procedures and adequate resources, and are motivated to change, practice may not change because of a lack of, or inadequate, systems [2]. At present it can be difficult to establish whether any given patient found to have AF and not on antithrombotics has ever been considered for them and appropriately excluded. The patient may not know and the old notes may be unavailable. In the context of an emergency medical service with acutely ill patients, the need to pursue this may initially be low priority and subsequently forgotten. Ideally, a patient’s medical history would be readily available whenever they see a doctor and in a format that would make it easy to find out about the AF and antithrombotics. Information technology is being developed to enable linkages between diagnosis, age and prescribing [7]. In the meantime, the challenge is to adapt existing systems so that any prescription of digoxin or amiodarone without associated warfarin would trigger the pharmacist to ask the doctor whether the patient had AF and if so, what about warfarin?

Such an initiative would be in keeping with the English National Service Framework for Older People [8]. The accompanying booklet, *Medicines and Older People*, raises the profile of pharmacy services and sets the expectation that pharmacists will be working much more closely with other health professionals to improve prescribing practice and gives case finding and appropriate prescribing of antithrombotics in AF as an example [7].

Practising evidence-based medicine needs to be made as easy as possible and until problems caused by systems are resolved, practice cannot be standardised and the quality of care provided will vary.

A less widely recognised barrier to implementing evidence-based practice is the patients themselves. A quarter of patients with AF in an English general practice, who were at risk of thromboembolism and eligible for warfarin, refused to take it—even when fully informed about the nature and consequences of having a stroke, aspirin and warfarin treatment, their predicted annual risk of stroke and the expected benefits of treatment [9]. What seems to be a worthwhile benefit at the population level may not be perceived to be great enough at the individual level for that person to be willing to take warfarin. In the same study, another quarter of patients were not prescribed warfarin, as they were too ill or unable to give informed consent.

**Primary care**

While it is important that those of us in secondary care manage patients with AF optimally, the greater responsibility lies with primary care, as patients spend most of their lives at home and it is here that AF can be managed in the context of the other priorities in stroke prevention.

Ownership by primary care is essential in order for the full resource implications of increased warfarin prescription and monitoring to be calculated and for the resources to be made available. In the absence of an appropriate infrastructure, there can be no standardisation of clinical practice. Once that is in place, it would be reasonable to expect registers of patients with AF to be
kept in primary care and that whenever a patient with AF was referred to secondary care this fact—as well as their antithrombotic status—would be communicated to the hospital.

One risk factor among many

AF is a risk factor for stroke but given that 87% of people who have a stroke are not in AF, it has to be managed along with the other modifiable risk factors such as hypertension and smoking [8]. Stroke prevention involves health promotion designed to reduce risk factors for stroke in the general population and the development of systems to identify and treat those at risk of first or repeat stroke. This requires protocols for primary and secondary prevention that are agreed between primary care and the local specialist services, and clinical audit systems for stroke.

Whether we are generalists or specialists, we are increasingly being required to standardise our practice and to show that we are doing so.

References


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