

## Debate

# Renewing professionalism: the next challenge for clinical governance?

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## Introduction

The term clinical governance was coined seven years ago to define a new development in systems to assure the quality of care delivered by healthcare services. It was a feature of the UK healthcare reforms of the late 1990s, but has since attracted the interest of policy-makers in other countries. The aim of this paper is to address the question: ‘What has been achieved?’. Health service organisations in the UK have been seeking to implement clinical governance over the last five years, and it is now appropriate to ask what progress has occurred. The paper also considers the implications of clinical governance for doctors. Increasingly, it is becoming apparent that quality rests on the motivations and energies of health professionals. Is clinical governance the way to maximise these motivations and energies, and if not, what should be done?

## What has been achieved?

Some information about the success of healthcare organisations in implementing clinical governance can be found from the clinical governance reviews undertaken by the Healthcare Commission (formerly CHAI and CHI). These reviews in their original format involved appraisal of documents, minutes and reports of quality activities of the healthcare organisation. This information was supplemented by a visit to the organisation that lasted approximately five days and involved interviews of samples of staff and patients.

The components of clinical governance were graded by the commission from one to four, one representing little or no progress, two some progress, three good progress and four excellence. Few if any organisations have yet reached level four, and most have been graded at level one or two. Development appears to be slower in primary care than in hospital trusts. On the evidence

of the reviews undertaken thus far, the commission has highlighted several key weaknesses.<sup>1</sup>

- As yet, healthcare organisations are making poor use of information within their clinical governance systems. Routinely collected data and data from clinical audit are rarely used in a systematic way to drive strategic development or clinical policies, and trust boards fail to make adequate use of clinical governance information in their long-term plans.
- Teamwork in healthcare organisations is sometimes unsatisfactory. Poor communication within teams, poor leadership, and poor multiprofessional co-operation hamper the quality of care.
- The commission has also found that good ideas or innovations in service delivery may occur in many healthcare organisations, but there is inadequate dissemination of the lessons learnt to other teams in the organisation, or between organisations. Consequently, the pace of improvement is slow.
- Involvement of patients and public in clinical governance is relatively limited. Patients have only a minor role in setting standards at the level of the healthcare organisation. Although patient surveys are commonly undertaken, often the findings are not used to change policies in a significant way.

In 2003, an evaluation of clinical governance was undertaken by the National Audit Office (NAO).<sup>2</sup> This study involved a survey of all trusts and interviews of key staff, including those at the Department of Health. The structures to support clinical governance such as appointment of leads and agreement of policies had generally been developed, although there were reservations about progress in clinical areas or in moving beyond the structural agenda. The NAO were critical of the use of information, pointed out that internal reporting systems needed development, and noted that staff needed support in continuing professional development and clinical audit. Trusts were also failing to benchmark their progress in comparison with others, and sometimes did not act on the recommendations made to them after a commission review. Achievements were therefore viewed as modest.

In a study of clinical governance in primary care trusts (PCTs), the finding that structures had been set up, but tangible outcomes in quality had yet to be achieved was confirmed.<sup>3</sup> Cultural barriers to progress included the development of trust between managers and clinicians that would enable quality problems to be discussed and addressed. However, the obligations of managers to root out poor performance was acting as a barrier to the generation of confidence in clinical governance among clinicians.

A review of the commission's reports on clinical audit in PCTs has confirmed that this element of clinical governance is yet to be adequately developed, despite support for audit in the health service for more than a decade. Seventy-three per cent of PCTs have been advised by the commission to disseminate the findings of audit more effectively, 68% to develop an audit strategy, and 60% to provide training programmes for all staff.<sup>4</sup> The authors of this review produced advice to PCTs to remedy the deficiencies identified by the commission. The advice began by recommending that audit findings should be discussed at trust board meetings. This is another illustration of the progress that is yet to be made. Although trust chief executives are now accountable for quality of care, the most basic activity needed to fulfil this accountability, namely discussion among the leaders of the trust about findings on quality of care in their trust, is not yet routinely in place. In its first report on the state of healthcare, the commission included development of auditing clinical quality as one of its priorities.<sup>5</sup>

In a separate study of the impact of clinical governance and commission reviews undertaken in six trusts, 163 staff took part in focus groups.<sup>6</sup> Doctors were found to regard clinical governance as management intrusion and were indifferent to its capacity to enhance clinicians' ability to improve care. Nurses were relatively indifferent to clinical governance, although they tended to believe it would enhance clinicians' capacity for improvement. Managers saw clinical governance as a positive development, but did not believe it would enhance clinicians' improvement capacity.

Further evidence about the progress and achievement of clinical governance is found in a recent extensive review of quality of care in England and Wales by Leatherman and Sutherland.<sup>7</sup> They found that clinical governance was understood in different ways, it had empowered managers but may have consequently excluded clinicians, and that trusts were struggling with transforming the concept of clinical governance into concrete action. Nevertheless, quality had become a necessary rather than optional concern to trusts and their managers.

There have also been some improvements in healthcare in recent years, although the role played by clinical governance is unclear. There has been a steep

decline in the numbers of patients waiting 12 months or more for admission for routine surgical procedures, mortality rates for circulatory disease and cancers are declining, but there are no improvements in patients' assessment of care, MRSA infections, breast and cervical cancer screening rates, immunisation against influenza, or waiting times for consultations in family practice.<sup>7</sup>

Clinical governance is still a new initiative.<sup>8</sup> It is a substantial programme, and a considerable challenge to the managers and professionals of the trusts which have to introduce and integrate the new activities while at the same time provide a service to an increasingly demanding and critical public. Consequently, it is too early to come to a definitive conclusion about its impact. An interim view is all that can be formed at this stage in its development.

Its benefits thus far include the introduction of several systems to improve quality, including adverse incident reporting and patient safety procedures, and the co-ordination of other activities such as clinical audit, use of guidelines, and evidence-based practice. There are examples of the duty of accountability imposed on trusts leading to beneficial change, and other examples of service redesign that have improved aspects of care.<sup>9</sup> However, two key weaknesses remain. The first is that chief executives and trust boards do not yet routinely review performance data, nor do they use such data to drive local policies or generate a culture conducive to clinical governance. The second is that much of the activity has yet to engage doctors. Unless doctors are fully engaged in clinical governance the likelihood of significant quality improvement will be low.

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## What are the implications for doctors?

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Doctors are under attack from several directions, not only in the UK, but also in many countries. Health service reforms are everywhere, driven by the need to contain spiralling costs and evidence of variations in the quality of care between organisations, teams and individuals. At the same time, new technologies to manage services have been introduced. These include evidence-based guidelines that describe the care patients should be offered in the greatest detail, and new electronic information systems that incorporate electronic clinical records and provide accessible data for monitoring performance.

At the same time, major changes have been taking place in the societies of developed countries. The public no longer regards professionals of almost any sort with unquestioning respect. Teachers, police officers,

lawyers and doctors can all be questioned and criticised.

Many countries have suffered serious adverse health-care events, but few countries have had such a succession of events as the UK. These have accelerated the growing willingness of the public to question health professionals. At the same time, many countries have experienced some fragmentation of professional structures. Increasing specialisation has increased the number of professional bodies, and the medical profession no longer has a single, united voice. The consequences of fragmentation have been exacerbated by government policy, which has been to confront the professions and weaken their ability to resist reform. No newly elected government wants doctors to delay or obstruct the implementation of their ideas for the health service. Thus, the leadership of the medical profession is weaker, and doctors find themselves in a more difficult world, and with less certainty about their sense of direction. McKinley and Marceau have described the confluence of such factors as 'the end of the golden age of doctoring'.<sup>10</sup>

Clinical governance involves some transfer of accountability for quality from health professionals to managers of services. Managers and policy makers are in consequence increasingly involved in decisions about clinical services. Since doctors might regard clinical governance as another step in their loss of control over their professional task, there is a consequent risk of disengagement of doctors from clinical governance. Indeed there is evidence from the studies referred to earlier that some doctors regard clinical governance as the business of managers – and perhaps also that some managers are unsure how to resolve this problem. Clinical governance may be regarded as a response to failed professionalism – since doctors were unwilling to take robust measures to improve the quality of care, the state and its managers had to step in. Whatever the truth of the matter, the medical profession now finds itself with less control over its own work, with weakened leadership, and less trusted by managers and the public.

Facing up to the challenge of quality improvement requires an empowered medical profession, and that requires effective leadership of the profession. It is possible that doctors' disengagement could be reduced through the development of local vigorous clinical team leadership such as that being promoted by the Clinical Governance Support Team.<sup>11</sup> Undoubtedly progress has been made towards the development of clinical leadership in some healthcare organisations. However, this is leadership promoted by the healthcare organisation and the state health service. It is not leadership provided through professional organisations and founded on a spirit of professionalism.

Effective clinical care, truly designed to meet the needs of individual sick people, requires health

professionals who are willing to exercise clinical judgement within a context of trust. They require discretion to take decisions that are in the patient's best or expressed interests rather than decisions dictated by the organisation or the state. If this is so, and I believe it to be so, then there is a limit to how a managerial approach to quality improvement can achieve all the progress we wish to see. Quality care requires that doctors themselves must be truly and deeply committed to quality improvement, and empowered to put that commitment into effect. Clinical governance has yet to achieve that goal.

The next stage of quality improvement or clinical governance must involve renewal of the spirit of professionalism.<sup>12,13</sup> This requires the creation of coherent, vigorous leadership of the medical profession, through renewal of the colleges and academies that represent doctors; national, professional leadership is required in addition to local leadership of clinical teams. The renewal of professional leadership cannot be achieved by doctors alone. Collaboration between policy makers and doctors is needed since health service policy must support the process. It will also demand courage among doctors' leaders. They will have to confront deep-seated attitudes among many of their colleagues, and educate managers and policymakers in their responsibilities for creating a vigorous profession.<sup>14</sup>

Clinical governance has brought healthcare services in the UK an enormous distance. It has now brought us face to face with the immutable fact of quality healthcare: quality care requires quality healthcare professionals who have the courage to confront and address poor quality, and work together guided by a shared acceptance of their professional duties.

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