

Introduction to Clinical Governance – A Background Paper



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Clinical Governance: Background paper

Governance ensures, on behalf of the owner(s), that an organisation does what it should and avoids what is unacceptable.¹

Clinical governance is the term applied to collecting all the activities that promote, review, measure and monitor the quality of patient care into a unified and coherent whole. In Western Australia, it has been defined as

a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes.²

Clinical governance is the main vehicle by which hospitals are held accountable for safeguarding high standards of health care (including dealing with poor professional performance), for continuously improving the quality of their services, and for creating and maintaining an environment in which clinical excellence can flourish.³

The activities encompassed by clinical governance are not new. Clinicians have always been concerned to offer the best standard of care to their patients. Many doctors audit their personal practice and their patients' outcomes and actively pursue their own professional education and development. As attention to evidence-based medicine is making relevant information more accessible, clinicians are comparing their customary practices against effectiveness standards, while medical indemnity organisations and hospitals work energetically to reduce and manage clinical risk.

Usually, however, these activities have grown in a piecemeal and sketchy fashion into a 'quality jigsaw'. Fears, particularly of legal confrontation, mean organisations have been slow to acknowledge and learn from mistakes and particularly to share that learning with outsiders. This is compounded by a widespread hospital culture that attributes error to human failing. Clinical error investigations have tended to concentrate on finding a culprit, rather than recognising that health care staff

constantly strive to do their best for their patients, but in an imperfect and sometimes inadequate environment.

Structural changes have affected how hospitals organise, deliver and review standards of care. Some have led to real service improvements, particularly where senior clinicians have been given responsibility for healthcare delivery and performance in clinical directorates. On the other hand, dividing the hospital into directorates has sometimes focused specialists' interests even more strongly within their own areas, leading to competition for resources and restricting interaction.

Consequently, the chance to use lessons from errors to benefit other patients, even within the same institution, has sometimes been lost. By bringing together all clinical quality activities under a single umbrella, clinical governance tackles these barriers, ensuring quality improvements can benefit the whole organisation.⁴

The introduction of clinical governance is therefore aimed at improving the quality of clinical care at all levels of an organisation by consolidating, codifying, and standardising organisational policies and approaches, particularly clinical and corporate accountability.⁵

Clinical governance has a number of parallels to corporate governance.

"The resonance of the two terms is important, for if clinical governance is to be successful it must be underpinned by the same strengths as corporate governance: it must be rigorous in its application, organisation-wide in its emphasis, accountable in its delivery, developmental in its thrust, and positive in its connotations."⁶

According to the OECD principles of corporate governance, well-managed organisations are those in which financial control, service performance, and clinical quality are fully integrated at every level. In health, this will require each service to work out its accountability arrangements in detail and ensure these arrangements are known by all stakeholders throughout the organisation.⁷

1 Carver J *Boards that make a difference* (1990) Jossey-Bass San Francisco

2 *Clinical governance, A Framework of Assurance* Department of Health 2001

3 Adapted from Scally G, Donaldson L, (1998) *Clinical Governance and the drive for quality improvement in the NHS in England* *BMJ*;317:61-5

4 Adapted from Scally G, Donaldson, (1998) *Clinical Governance and the drive for quality improvement in the NHS in England* *BMJ*;317:61-5

5 Adapted from Scally G, Donaldson, (1998) *Clinical Governance and the drive for quality improvement in the NHS in England* *BMJ*;317:61-5

6 Adapted from Scally G, Donaldson, (1998) *Clinical Governance and the drive for quality improvement in the NHS in England* *BMJ*;317:61-5

7 Adapted from Scally G, Donaldson, (1998) *Clinical Governance and the drive for quality improvement in the NHS in England* *BMJ*;317:61-5

Where has clinical governance come from?

Business concerns about financial control and risk management, especially in publicly listed companies, spawned the concept of corporate governance (sound business and financial management) during the late 1990s⁸. This emphasised rigorous and transparent probity standards throughout an organisation and made the company executive accountable for their delivery.⁹ The concept has been widely welcomed and is rapidly gaining acceptance, particularly as companies recognise corporate governance both develops their business interests and has a positive approach.

Over the same period, concerns about the quality of health care suggested the idea of 'governance' might have a clinical application.

Do we really need clinical governance?

1. THE VIEW FROM INSIDE

Where attention focuses less on clinical priorities than on activity targets, waiting list initiatives and financial issues, physicians can become frustrated and demoralised¹⁰. Clinical governance gives delivering high quality health care its rightful status alongside service performance and financial control within each area health service as well as throughout the whole health care system. However, as treatment possibilities expand, the social setting in which health care is provided is also becoming increasingly complex.

The delivery of health care faces many challenges and changes, including an increase in demand for quality health services. Changing work patterns, while bringing important benefits, bring additional responsibilities and risks. Traditionally, junior doctors provided continuity of care for patients at the cost of punishingly long hours and personal sacrifice. Limiting their hours of work reduces the risk of errors provoked by fatigue, but heightens the necessity of good communication between successive shifts.

The largest occupational group within the Western Australian healthcare system, in 2000, some 25,600 nurses were registered with the Nurses Board of Western

Australia. These nurses also face new challenges in providing quality health services as their role now includes more demanding scientific monitoring, measuring and recording responsibilities, which has resulted in new barriers between nurses and their patients.¹¹ As the relationship between nurses and patients changes its focus and intensity, the old and subtle safety net of daily conversation, which might have previously alerted a nurse to an error or an omission, may be lost.

Nurses now report they do not feel valued by the system and this in turn has resulted in a fall in the nursing workforce locally¹² as well as worldwide. Hospitals are thus forced to employ more temporary staff, who may not be familiar with a ward's routines or protocols and who may be directed to different wards on successive shifts.

Patients now spend only the most acute phase of their illness in hospital. Many different professional groups - and sometimes agencies - may participate in the episode of care, particularly when the pre-admission, sub-acute or rehabilitation phases are considered. As more individuals from more groups look after a patient within a tighter time frame, maintaining a consistently high standard of care - even across a single health care episode - becomes more challenging. The potential for error increases, particularly whenever responsibility is handed from one agency to the next. Each transfer requires comprehensive, accurate and timely communication, irrespective of distance, shift patterns or competing clinical demands.

Failure of care - whether through error, ignorance or omission - has big opportunity costs. The individual patient pays with physical and/or psychological discomfort, lost work or school days, and sometimes a restricted or diminished future. The population pays as health dollars are diverted from prevention, diagnosis and treatment to insurance premiums and the management of adverse outcomes. Health care staff pay as they become disheartened and frustrated and the public loses trust in its health system.

Operating in a complex and demanding environment, the health system must acknowledge and respond to these clinical and social challenges. At the same time, it must be seen to be doing what it says it does. Clinical governance offers a way to achieve this.

8 *International Corporate Governance Network: ICGN Statement on Global Corporate Governance Principles adopted Frankfurt 1999.*

9 *OECD Principles of Corporate Governance May 1999*

10 *Lazare A (1987) Shame and Humiliation in the Medical Encounter Arch Int Med 147:1653-58*

11 *Pinch, C. & Della, P. (Eds). 2001 The West Australian study of nursing and midwifery: New Vision New Direction. Perth: Department of Health http://www.nursing.health.wa.gov.au/documents/NVND_Report.pdf*

12 *Pinch, C. & Della, P. (Eds). 2001 The West Australian study of nursing and midwifery: New Vision New Direction. Perth: Department of Health http://www.nursing.health.wa.gov.au/documents/NVND_Report.pdf*

Do we really need clinical governance?

2. WHAT DOES THE PUBLIC SEE?

Assailed almost daily by media reports of seemingly limitless medical discoveries and advances, the public's expectations of its health service have never been higher. At the same time, a string of medical disasters has received extensive coverage. In Britain, the Bristol cardiothoracic inquiry into unacceptably high levels of perinatal mortality¹³ received regular media attention over its three-year lifespan. During the same period, British GP Harold Shipman was convicted of killing at least 15 of his middle-aged and elderly women patients.

In the US, a high-profile health reporter for the Boston Globe newspaper died after a massive chemotherapy overdose at the age of 39, while she was being treated for breast cancer at a highly respected specialist cancer institute. A similar overdose had been given to another patient at the institute one month earlier. Although the hospital responded in traditional manner by disciplining 16 nurses, the media took perhaps a more considered view. The Globe itself said the action was "misguided because it focuses on the individuals even though the errors were caused by failures in the design of the medication system."

In Western Australia, the Douglas Inquiry¹⁴, which investigated clinical and management practices at King Edward Memorial Hospital between 1990-2000, has received much attention nationally, particularly with respect to the Inquiry's findings of poor policies and practices and inadequate systems that resulted in poor outcomes for patients and their families.

However, individual examples such as these seem to be emblematic of system-wide concerns. Research papers published in Australia, New Zealand, the UK and the USA have all reported previously unrecognised levels of

iatrogenic injury to patients.

As long ago as 1974, Californian hospital records¹⁵, and New York State hospital results ten years' later¹⁶, showed unexpectedly high rates of adverse events. In the New York study of 51 acute care, non-psychiatric hospitals, 3.7% of more than 30,000 inpatient episodes included a harmful adverse event, and in 0.7%, patients suffered permanent disability or death. Neither study, however, led to any substantial change in hospital practices.

The next major report came from Australia in 1995¹⁷, and this showed 16.6% of admissions to Australian hospitals during 1992 were associated with an iatrogenic injury and death resulted in almost 5% of these cases. Importantly, the specialist panel reviewing these cases felt half of the adverse events were potentially preventable. The authors concluded the emphasis should be to design safer systems to protect patients from "the inevitability of human error"¹⁸. Making the system safer, and aligning the priorities of management with those of clinicians, were the solutions, they said.

Two other, more limited, reports - one from the UK¹⁹ and the other from New Zealand²⁰ found similar rates of adverse events (10.7% and 10% respectively) and potential for prevention (46% and 40%).

The New Zealand errors led to an average extra 6.7 days of health care per event, while extrapolating the UK results, errors could account for expenditure of £1 billion pounds a year²¹.

In the USA, a Juran Institute study found 30% of all direct healthcare spending was the result of poor quality care - particularly due to overuse (including of investigations and some medications), misuse (such as drug or equipment misuse) and waste (particularly unnecessary administrative

13 *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 - 1995* <http://www.bristol-inquiry.org.uk/index.htm>

14 Douglas N, Robinson J, Fahy K (2001) *Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital.* <http://www.health.wa.gov.au/kemhinquiry/>

15 Mills DH (1978) *Western Journal of Medicine* 128:360-5

16 Brennan TA, Leape LL, Laird LM et al (1991) *Harvard Medical Practice Study New England Journal of Medicine* 324:370-6

17 Wilson RM, Runciman WB, Gibberd RW et al (1995) *Quality in Australian Health Care Study (1995) Medical Journal of Australia* 1995:163:458-71

18 Wilson RM, Harrison BT, Gibberd RW, Hamilton JD (1999) *An analysis of the causes of adverse events from the Quality in Australian Health Care Study MJA* 170:411-415

19 Woloshynowych M, Neale G, Vincent C (2000) *Adverse events in hospitalised patients: a pilot study and preliminary findings Clinical Governance Bulletin* 1:2-3

20 Davis P, Lay-Yee R, Schug S, Briant R et al (2001) *Adverse Events Regional Feasibility Study NEJM* 114:200-5

21 *Clinical leadership and clinical governance: a review of developments in New Zealand and Internationally (2001) published by Clinical Leaders Association of New Zealand Inc.* www.clanz.org.nz/downloads/files/ACFBEC.doc

activity)²². As the lead author of the Quality in *Australian Health Care* report told Norman Swan on ABC radio, "There's no question just as it is in the manufacturing industry, it's cheaper to do it right the first time."²³

Interest in reducing clinical error sparked a major report by the US Institute of Medicine of the National Academy of Science, *To Err is Human: Building a Safer Health System*²⁴, which suggested 48,000 to 98,000 American in-patients die from iatrogenic errors annually. In this report, patients whose stories were already public were named, and otherwise dense statistics made accessible by comparisons with deaths from drunk driving and breast cancer.

This time, media attention ensured rapid responses from both President and Congress in the States and even spawned a four-part television documentary in Britain, *Why Doctors Make Mistakes*²⁵. Patient safety also made the front page in the Canadian news magazine *Maclean's*²⁶.

A public poll by the Kaiser-Harvard Health News Index four weeks later showed over half of those interviewed knew about the Institute of Medicine's findings.

How are international health systems responding?

Reports of adverse events are naturally unwelcome. They generate alarmist media reporting and deflect attention from the quality health care and satisfactory outcomes most patients enjoy (which are not news because they happen all day, every day). They also risk damaging public confidence in particular health care institutions, but ignoring or disparaging the reports' findings is neither clinically nor economically wise.

Perhaps surprisingly then, USA health care providers have paid little attention to clinical governance. There has been little public demand for higher quality care and little information technology developed that can bring together the innumerable data sets that are collected. Clinical quality initiatives abound in the commercially-driven American health system, but tend to be of interest mainly to administrators. These reflect commercial business

improvement systems such as Total Quality Management and the International Standards Organisation 9000 series guidelines, which deal mainly with documentation, standardisation and reliability of management policies and procedures. There is little evidence that any of these systems have resulted in any underlying performance improvements²⁷. Perhaps as important, corporatised American medicine has fragmented and limited clinical leadership. Clinicians tend to have minimal influence, except in financial areas and share few values with administrators.

In contrast, clinical governance is perhaps best developed in Britain, where Professor Liam Donaldson (now England's Chief Medical Officer), actively promoted clinical governance, even before Bristol and Shipman raised questions about quality and safety in the NHS. The UK government is building its reform of the NHS on clinical governance, establishing National Service Frameworks, the National Institute for Clinical Excellence (NICE) and a Commission for Health Improvement (CHI). The CHI investigates serious complaints about quality of health care, and also undertakes a comprehensive program of inspection visits to review clinical governance arrangements in individual hospitals, including within the private sector.

Since its establishment in April 2000, the CHI has undertaken 74 routine reviews of clinical governance and six serious investigations. Investigations have been undertaken because of problems such as the abuse of elderly patients in one Trust, the employment of poorly performing consultant locums and breast screening management failures. Some of the CHI's recommendations following their investigations have resulted in new national codes of practice.

The three Departments of Health in Britain have also linked risk management directly with resource savings. Hospitals achieving specific standards of practice in ten prescribed areas (such as informed consent, patient health records, clinical incident reporting and induction and training) receive a reduction in their clinical negligence insurance premiums of up to 20%²⁸.

22 *Midwest Business Group on Health & Juran Institute (2002) Reducing the Cost of Poor-Quality Health Care Through Responsible Purchasing Leadership; reported in BMJ 2002;324:1478*

23 *Ross Wilson interviewed by Norman Swan Quality in Australian Health Care on The Health Report broadcast July 7th 1997*

24 *To Err is Human: Building a Safer Health System (2000) Institute of Medicine, National Academy of Sciences*

25 *Broadcast Channel 4 October 2000*

26 *February 14th 2000*

27 *Blumethal & Kilo (1998) A Report on Continuous Quality Improvement. Millbank Quarterly 76(4):625-48 quoted in Wright I, Barnett P, Hendry C (2001) Clinical Leadership and Clinical Governance: A review of developments in New Zealand and internationally*

28 *Clinical Negligence Scheme for Trusts (in England), administered by the NHS Litigation Authority <http://www.nhsla.com/>*

In Australia, NSW has introduced its *Framework for Managing the Quality of Health Care Services in NSW*, a comprehensive guide to the organisational changes required within the state's healthcare system to establish clinical governance in that state.

One NSW Area in particular, Hunter Health, has been very active in developing a model for clinical governance²⁹, centred on a new Unit for Clinical Governance, to which every other area committee (except the Medical Appointment and Advisory Committee) reports.

The Area has redefined the role of their Directors of Medical Services (DMS) to focus almost exclusively on patient safety and clinical governance. Other traditional DMS duties have been deleted and these positions now report through the Area's Clinical Governance Unit to the Area executive.³⁰

Across the Tasman, clinical governance has some notable differences from both the British and Australian models. The concept is best developed among primary care organisations (PCOs), where clinical leadership has been a key-driving factor and clinicians have accepted substantial accountability for quality and for cost. However, the integration of clinical governance throughout organisations has tended to be weaker through this 'bottom up' approach³¹.

Applying the principles of corporate governance to clinical practice offers a way to address patient, clinician and

public concerns in a transparent and coherent way. It is important to recognise however, that while patients benefit immediately, system-wide quality improvement is a long-term outcome and financial benefits will only be realised gradually.

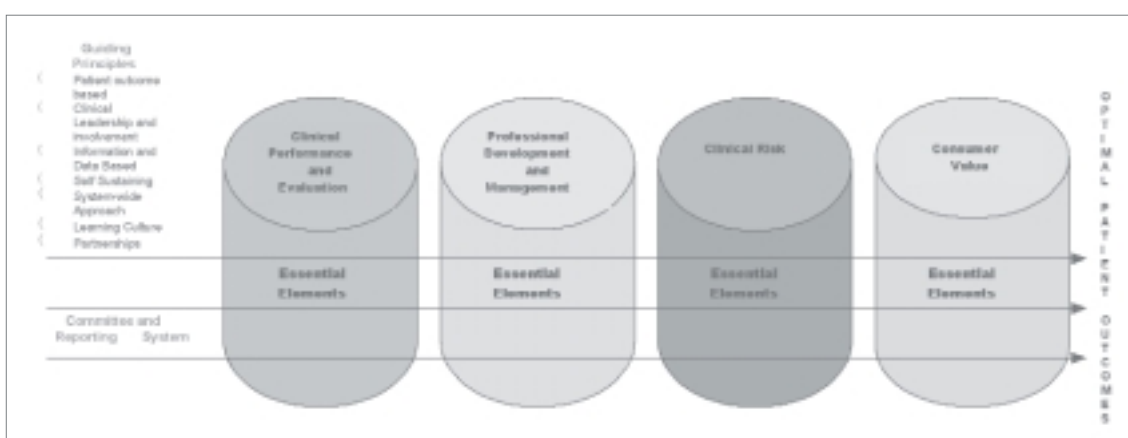
What does clinical governance include?

In WA, the Department of Health has described a new model for Clinical Governance for development and implementation in the state's hospitals and health services. This is based on four pillars and encompasses clinical audit, clinical risk management, clinical effectiveness and knowledge management, professional education and development, to give a whole-of-systems approach to quality improvement.

1. CLINICAL AUDIT

Clinical audit is the cyclical process of reviewing clinical performance, refining practice as a result and measuring the outcomes against agreed standards. Part of good clinical practice for generations, audit is practised at a number of levels, from regular morbidity and mortality reviews through to national studies. There are many successful examples of its application, such as the national audit of stroke, undertaken in the UK. Over 80% of acute trust hospitals participated in the first round of this

FIGURE 1: CLINICAL GOVERNANCE FRAMEWORK FOR THE WA PUBLIC HEALTH SYSTEM³²



29 "Implementing a Clinical Governance Model" for the Opening Plenary Session, Annual Scientific Congress, Royal Australasian College of Surgeons in Adelaide on 11 May 2002.

30 Director of Medical Services Role Restructure, summarised at <http://www.hunter.health.nsw.gov.au/index.php?p=2621&PHPSESSID=2e03375392a80df614ca6c26917b9ffb>

31 Wright I, Barnett P, Hendry C (2001) *Clinical Leadership and Clinical Governance: A review of developments in New Zealand and Internationally*

32 Department of Health (2001). *Clinical Governance, the Framework of Assurance*, Department of Health of WA, 2001.

exercise, contributing nearly 7000 cases. A year later, the second round of the audit found participating trusts had improved services against 29 of 38 organisational standards and 64 of 71 process standards, often directly attributable to participation in the audit.³³

In WA, the Department of Health has supported the development and implementation of the WA Audit of Surgical Mortality (WAASM), based on a similar Scottish Audit of Surgical Mortality. WAASM monitors and audits the incidence of surgical mortality in WA public hospitals, and helps ensure the optimal peri- and post-operative health care in Western Australia. WAASM began in November 2001 and all surgical deaths in the State are now audited by senior surgeons.

Ultimately, WAASM is expected to enable clinicians, health services and researchers to compare surgical mortality outcomes in Australia and WA with international surgical outcomes. Importantly, by demonstrating that a systematic, state-wide audit of surgical mortality outcome is possible, WAASM should encourage other national projects.

Measuring aspects of health care in ways that are meaningful to clinicians and that allow both internal comparison and monitoring of performance and external comparison with peer hospitals is an important step towards quality improvement. Any measures must however be clinically relevant and appropriate. Some techniques, such as some clinical indicators or mortality figures, while they work for some disciplines, may be too crude at the moment to yield useful information or are simply inappropriate in other specialties. Continued clinical input is essential to refine the questions into ones that really benefit and develop patient care. "If you do not know how to ask the right question, you discover nothing³⁴", the father of quality systems, WE Deming, said.

2. CLINICAL RISK MANAGEMENT

Clinical risk management considers how to identify and reduce or prevent adverse events for patients, and promotes learning from complaints, critical event audit (including near-misses) and identifying and dealing with poor professional performance. In one example, the National Patient Safety Agency in England identified 31 incidents and three deaths from incidents involving

potassium chloride phials in nine months. As a result, the agency issued an alert to all hospitals and is helping manufacturers develop a suitable range of diluted products and consider changes to packaging.³⁵

However careful and thorough, everybody makes at least the occasional mistake, but such errors can be difficult to predict because of their very rarity and unpredictability. Systems can help limit the consequences of some errors. Monitoring standards allows an early warning system of potential problems, and in this context, patterns of errors are probably more significant than individual mistakes.

Media and community demands for blame³⁶ and compensation sometimes fail to recognise the enormous pressures individual clinicians can be placed under. Very few doctors perform consistently poorly, and at least some of these are likely to be working in areas with system-wide problems. 'Human beings make mistakes because the systems, tasks and processes they work in are poorly designed.'³⁷ One of the strengths of clinical governance is to allow all of the issues to be considered.

3. PROFESSIONAL DEVELOPMENT AND MANAGEMENT

The job of weighing and balancing the evidence on particular topics (knowledge management) is being made much easier for clinicians through a range of organisations, including the Cochrane Collaboration and the various national and international bodies producing evidence-based guidelines.

Professional education and development includes credentialling (recognising the adequacy of individuals' training and experience for their scope of work) and performance appraisal.

Regular review of professional practice is an important aspect of clinical governance and implies education and professional development are recognised and supported. It is not primarily there to catch poor performers and it is applicable at all levels of practice as well as to non-clinical areas.

Internationally, licensing bodies are introducing revalidation standards and asking practitioners to demonstrate their knowledge and activities reflect current practice standards. In Australia, this has largely been the

33 Rudd AG, Irwin P, Rutledge Z, et al (1999) *The national sentinel audit of stroke: a tool for raising standards of care* J RCP London 33:460-4

34 WE Deming

35 Vass A (2002) *Patient safety agency admits problems with its pilot scheme* BMJ 324:1473

36 AlleyneR Surgeon ignored student's warning over fatal error Daily Telegraph June 13 2002

37 Dr Lucien Leape, quoted in *Clinical Governance Bulletin* Dec 2001 p1 <http://www.roysocmed.ac.uk/pub/cgbdec01.pdf>

province of the specialist medical colleges. Whilst some hospitals and health services already have credentialling and clinical privileges processes in place, this has not been universal. Therefore, the introduction of a clinical governance policy across the health system is intended to assist other hospitals and health services to develop and implement their own credentialling and clinical privileges processes, thus ensuring the ongoing maintenance of professional standards for their staff.

What are the barriers?

The commitment to the provision of a high quality health service is real and deeply held throughout the Western Australian health care system. As a result, clinicians should not hesitate to encourage debate on how services could be improved and made better.

However, in the context of changes to how medicine is regulated, increased litigation, media attention and higher public expectations, it would be surprising if clinical governance was not regarded with some suspicion by doctors as yet another way to challenge the profession.

For some clinicians, transparent accountability and responsibility throughout their direct and indirect contact with patients is integral to their work. Yet the medical profession has a long tradition of professional autonomy, collegiality and self-regulation³⁸, making the culture one where mistakes can be difficult to acknowledge. Doctors are less likely to report adverse events than other health professions.³⁹

But there is a subtle, but particularly powerful, influence within medical culture that makes even the concept of 'quality improvement' difficult to acknowledge for some clinicians: the fear of shame. Some years ago, when a large randomised controlled trial showed the only available oral

hypoglycaemic agent at the time, tolbutamide, was associated with increased mortality from myocardial infarction, the researchers were met with outrage. Legal proceedings were even started against them⁴⁰. The reaction stemmed in large part from the sense of shame doctors feared from telling their patients they had been prescribing an unsafe medication. Indeed, any 'improvement' activity is built on the notion that, however good things have been, they could be better.

Using shame to change behaviour undoubtedly works, but at a cost. Organisations as diverse as the European Commission⁴¹, the UK government⁴² and the OECD⁴³ have used it recently to force change in environmental management, business and health. The experience of shame in medicine however often operates differently; patients who see their illness as an inadequacy or a shortcoming may avoid consulting a doctor with the associated physical and psychological exposure^{44,45}. On the other side of the relationship, doctors can also feel shame and embarrassment, for example when a second opinion is asked for, or their advice is apparently ignored⁴⁶. Humiliation has been a widely used technique in undergraduate and postgraduate medical education⁴⁷.

Unless this pervasive but silent factor is acknowledged and accommodated, the attention clinical governance brings to medical errors may be strongly resisted.

Errors are often the culmination of a chain of events, involving people both close to and remote from the event. The external inquiry into the patient's death in Nottingham⁴⁸ following an intrathecal injection of vincristine found at least seven people had been directly involved in the sequence of events. A number of others contributed indirectly, by virtue of not putting safety protocols and procedures in place, or not checking those that did exist were being followed.

38 Rosenthal M How doctors think about medical mishaps In: Rosenthal M, Mulcahy L, Lloyd-Bostock S eds. *Medical mishaps* Buckingham Open University Press 1999:141-53

39 Lawton R, Parker D (2002) Barriers to incident reporting in a healthcare system *Qual Saf Health Care* 11:15-18

40 Davidoff F (2002) Shame: the elephant in the room *BMJ* 324:623-4

41 Margot Wallstrom Intensifying our efforts to clean urban waste water. European Commission, Brussels 2001

42 BBC (1999) Pesticide report to name and shame *BBC News* Sept 9th

43 OECD Financial Action Task Force on Money Laundering *OECD Observer* October 2000

44 Lazare A (1987) Shame and humiliation in medical encounter *Arch Intern Med* 147:1653-8

45 Keeling RP (2002) Fear Shame and health promotion *J Am Coll Health* 50:149

46 Buchman TG, Cassell J, Ray SE, Wax ML (2002) Who should manage the dying patient? Rescue, shame and the surgical ICU dilemma *J Am Coll Surg* 2002 194:665-73

47 Buchman TG, Cassell J, Ray SE, Wax ML (2002) Who should manage the dying patient? Rescue, Shame and the Surgical ICU Dilemma *Am Coll Surg* 194:665-673

48 Toft, B External inquiry into the adverse event that occurred at Queens' Medical centre, Nottingham on January 4th 2001 DoH

Unfortunately, medicine's authority structure can militate against a team approach to risk management. Some of the safeguards that come from open and constant communication, despite marked authority gradients, and that have been adopted by other high-risk professions, particularly airline pilots, may not operate well in medicine.

Blame necessarily impedes many quality initiatives and contributes to an atmosphere where staff report even small deviations from standards reluctantly. 'Where there is fear, you will get wrong figures'⁴⁹.

Concerns about confidentiality of reports and legal privilege may also limit clinicians' willingness to report, investigate and document adverse events.

Practical issues, such as adequate financial and staffing resources, can also affect whether clinical governance is both seen to occur and recorded. While many quality activities already happen, they are often not documented suitably for governance purposes. Other aspects of the program will be new or will involve participants for the first time. Change always costs time, energy and money and must be adequately recognised and resourced.

Structural barriers, such as the need for different professional groups to work closely together, can bring challenges of themselves. Different working routines as well as variations in age, educational level and clinical experience contribute to this, as are emotional barriers such as historical rivalries and fears that professional identities may be diluted.

None of these are overcome quickly or easily, but strong clinical leadership has achieved some notable successes, particularly in geriatric medicine in Australia and overseas.⁵⁰

Information must be collected and managed suitably if it is to support appraisal and other aspects of clinical governance. Suitable information technology must be available, and the information must be handled efficiently, accurately and promptly; staff must be confident the information can be kept confidential when necessary. This is an important example of how clinical governance brings together corporate and clinical interests to enhance patient care across the organisation.

But information is not an end in itself: "the purpose of data is action"⁵¹. The outcome of all governance activities must be to change behaviour - by recognising and disseminating examples of high quality services and by improving substandard activities.

One further barrier may also exist: the absence of any clinical governance success stories. There is a subtle tension here - clinicians are expected to test their practice against objective evidence of its clinical and cost effectiveness, yet they are also now asked to participate in clinical governance, for which there is as yet no such evidence. On the other hand, as clinical governance matures there is every reason to expect this will be overcome. In the meantime, success stories from individual components of clinical governance continue to grow.

Conclusion

Variation will always exist, even within a mechanical system doing the same thing repeatedly and to a high standard. Clinical governance is as much about recognising and spreading examples where a service is performing better than the average, as identifying and correcting services where the variation is below acceptable performance limits.

Achieving consistent, accurate and timely outcomes reliably has been recognised as essential to any productive activity since Deming introduced the concept of quality as a business tool. He took it as axiomatic that workers were craftsmen who wanted to do a good job. When they were prevented from doing so, he recognised this was both distressing and usually the fault of the system, rather than the individual. He emphasised the importance of a culture where staff were unafraid to come forward to report failures. His results - a quality product and satisfied customers, enthusiastic staff and lower costs - are exactly what health systems internationally are saying they want to see.

49 WE Deming

50 The John Hartford Foundation Annual report New York: the John Hartford Foundation, 2000

51 WE Deming



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