

## Clinical Governance

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Any National Service provided to the people, health care service being on top of the list, must be subject to the simple rules of quality control assurance.

This means that it must be equally available to everyone, at least at the minimum accepted standards of excellence. It also means that this service must be subject to accountability in cases of substandard care provision. This principle is a basic constitutional human right called for by the World Health Organization (WHO) human rights act and is part of the sacred oath that every health care professional makes at the outset of his/her career.

There is nothing new to the core of this ideology. But, the absence of a governing system of rules and regulations would eventually lead to individual variations in care. A system resembling the operating systems of any government is essential to educate and guide health care providers and to provide a framework of accountability and quality assurance on national levels.

That is why the health care profession has recently entered in a more mature era of true patient-centered care, based on the principles of customer-provider relationship where patients have the right to actively share in all their management decisions, based on clear, complete and evidence-based counseling.

This has led to the introduction of the concept of clinical governance in the developed world with the aim of delivering a high quality of healthcare with no major variations in the process, outcomes or availability of services.

Clinical governance can be defined as a system or framework through out which National Health Service organizations are accountable for continually improving the quality of their service and safeguarding high standards of care by creating an environment in which excellence in clinical care could flourish.

In simple words, it is a system that insures adequate standards of healthcare provision everywhere.

Although the concept of clinical governance may be new to many healthcare professionals, most of them are already practicing most of its principles, such as patients' right to receive complete information, patients' confidentiality, the need to evidence-based practice and continuous professional development as well as different ways of accountability.

What is new here is the systematic fashion of care, controlled by national authorities which insure equally adequate care for all.

Like in any national service, quality assurance in healthcare relies on the presence of the following authorities or regulating bodies:

**A legislative or guiding authority**; a body which designs the strategy of educating and training professionals, **an inspection authority** and last but not least, **a regulatory body** in charge of reforming any defects or negligence.

The basic principles of the **guidance (legislative) authority** are to put general recommendations or guidances, based on up-to-date evidence and to direct and encourage scientific research to develop or improve scientific information upon which guidelines are founded. Those guidances or recommendations may be in the form of national guidelines or local protocols tailored to specific circumstances and covering variable minor details.

This educational and training authority should be meant with undergraduate education, postgraduate continuous professional development and continuous medical education, re-training of the poorly performing professionals and training of clinical leadership.

This is of course in all the levels of healthcare; clinical, pharmaceutical, nursing, or technical.

The function of the **inspection authority** is to identify the points of weakness or substandard care in the system. This can be effective on national, organizational or individual levels. On national levels, Egypt is currently endorsing a strategy of confidential enquiries into critical deals of healthcare such as maternal and prenatal mortality rates. The results of the most recent maternal mortality enquiry report were discussed in a previous issue of ASJOG (Volume II, Issue 1, page 306).

Similarly, the Egyptian ministry of health has recently published a guideline on hospital accreditation standards (December, 2004) to define

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the good practice standards in all sectors of hospital care.

On organizational levels, a system of auditing and clinical risk management is required to apply the principle of clinical governance. Relevant and precious conclusions can thus be reached about any effects or causes of poor compliance with the good standards of care, and realistic reports can just be available to institutional decision makers as well as healthcare professionals and guidelines developing authorities.

Audit is defined as the periodical quantitative and qualitative evaluation of current local practice within an organization as compared to established gold standard defined by national guidelines.

A tailored description of the steps of the audit cycle might be a subject of a future article in ASJOG.

Clinical risk management can be regarded as the other side of the same coin and may be defined as the methods for early identification of adverse events or outcomes, using either staff reports, patients' complains or systematic screening of hospital records. This should be followed by creation of a database to identify and analyze common patterns of substandard care and to develop a system of correction and accountability to prevent future incidence.

Clinical risk management is a new concept which definitely deserves a detailed discussion in future issues of ASJOG.

On the individual healthcare providers' level, the national inspection authority may use the strategy of revalidation of the doctors or providers license to practice based on a well planed quality assessment strategy, which may include continuous medical education credit points.

Although this idea may be a source of great concern to some practitioners, yet it is a fundamental patient's right which insures that no healthcare provider would be expected to continue practicing unless he/she is up to date with the basic requirements of good practice. It is a reality in most of the developed countries soon to be seen as a world wide principle.

The *regulatory body* in charge of reforming defects or substandard forms of healthcare is a mandatory corner of clinical governance to impose serious adherence to the quality assurance measures. It should not be regarded as a potential threat to healthcare professionals or an excuse to defensive practice, as long as it is properly applied and as long as we all commit ourselves to our sacred oath to saving no effort in adequately serving our patients.

At the national and organizational levels, the

system of clinical governance may use the hospital accreditation standards to put incentives to organizations to adhere to clinical guidance.

Those incentives may be in the form of supporting or budgeting plans to the hospitals which fulfill the highest standards of good practice, which would encourage the spirit of ownership in hospitals leadership.

On individual level, the framework of clinical governance must cover important points such as a national policy of medical employment laws, consultant appraisal and revalidation. Our patients consult us expecting advice based on an up-to-date scientific background. This expectancy has become, in some countries, a legal prerequisite to periodic renewal of the license to practice of all practitioners at all levels of seniority. It will soon be a reality all over the world.

## Key Points

In conclusion, the concept of clinical governance may already be in practice everywhere but what is new is the creation of a systematic fashion or framework which presents clinicians with an opportunity to introduce systems into their daily practice which would enhance their ability to deliver high quality care and simultaneously improve their job satisfaction.

Clinical governance embraces the following systems:

1. Clinical audit (to check that the systems to monitor the quality of clinical practice are in place and are functioning properly, that clinical practice is reviewed and improved as a result, that clinical practitioners meet standards).
2. Effective management of poorly performing clinical colleagues.
3. Risk management.
4. Evidence-based clinical practice.
5. Implementation of clinical effectiveness evidence.
6. Development of clinical leadership skills.
7. Continuing education for all clinical staff.

## References

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