Clinical governance: an educational perspective

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Clinical governance is a novel concept with potentially profound implications for the practice of medicine in the next millennium. What the term might mean from the perspective of patients, and doctors in the health service of the future is explored in this article. All this has significant educational implications and these are considered.

Clinical governance is a central plank of government policy to put quality at the heart of the NHS (Department of Health, 1997). This article looks at what this means for the health service, and highlights some of the educational implications.

THE CURRENT CONTEXT

Great forces for change are fundamentally affecting the health service and the way we work within it. These include the rapid expansion of knowledge and possible skills, the revolution in technology which continually pushes out boundaries, and the increasing involvement in health care of a wider range of health professionals, accompanied by increasing complexity. Patients are demanding a much greater role. Doctors also desire a life outside of medicine.

THE CONCEPT

Clinical governance is a breathtaking idea, whose simplicity belies its complexity; many people outside the NHS are surprised at the lack of responsibility for its quality within the NHS at present.

The term is derived from the commercial world following a number of high profile institutional failures with significant losses of investor funds, and stems from the Cadbury report (Cadbury, 1992) now widely adopted in the public sector. In relation to hospitals the term is much older, going back to 1660 (Coke, 1992). In a modern context it can be viewed at three levels: strategic, systems and operational.

THE STRATEGIC IMPERATIVE

The consistent provision of high quality clinical care will only happen if there are effective partnerships between health professionals and managers within NHS organizations. For these to develop, major cultural changes need to occur. Doctors need to have respect for and trust other professionals and health service managers. Much will depend on the approach and style adopted by the fledgling clinical governance structures being established. If doctors (and other health professional staff) are not adequately trained or continually updated then patients, and the NHS trust responsible for their care, are at risk. These attitudes need fostering, including through multidisciplinary, multiprofessional training. Those involved in the management and delivery of postgraduate training therefore need including in relevant partnerships within the wider NHS and at strategic levels.

THE SYSTEMS DIMENSION

Clinical governance means integrating a number of existing systems, including clinical audit, the handling of complaints and clinical risk management, well described by the British Association of Medical Managers (1998). New systems also need to be developed and put in place. Lines of accountability need to be clearly defined. Good practice and evidence-based innovations will be systematically disseminated and implemented.

AT THE SHARP END: THE OPERATIONAL DIMENSION

To embed clinical governance in routine medical practice, doctors need appropriate attitudes, knowledge and skills. At present much time and effort is expended in inculcating trainees with (perfectly appropriate) specialist elements relevant to their chosen specialty and future clinical practice. To enable them to meet their responsibilities for clinical governance they also need to work in teams, be constantly constructively self critical (and hence play a full and proper part in

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clinical audit), be committed to continuing professional development (CPD), know how to avail themselves of and apply relevant best evidence, and meet the responsibilities set out in *Good Medical Practice* (General Medical Council (GMC), 1998a).

PATIENTS AND DOCTORS IN THE FUTURE

To consider what sort of doctor the NHS should develop for the next millennium we must look at the patient of the future since we are in the business of meeting their health needs.

Patients will be knowledgeable because they are increasingly better educated and have more access to the growing tide of information available through the media, the Internet and other sources. As a consequence they will have high expectations, and want much more of a partnership with doctors and other health professionals involved in their care. 'Do as I tell you' and 'Trust me, I'm a doctor' approaches will no longer endure. Patients are already more willing to complain.

Just as the information available to patients grows, so the knowledge and potential skills for doctors to acquire is expanding. Doctors of the future will be lifelong learners and evidence-based practitioners. Every doctor will need to be clinically competent and perform consistently well. While practising ethically and protecting patients from harm, future practitioners will need to contribute to care as effective team players. They will need to be committed to teaching and training, clinical audit and research, and maintain CPD with regular revalidation.

CPD has been defined as:

> **'a process of lifelong learning for all individuals and teams which meets the needs of patients and delivers the health outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential (Department of Health, 1998).'**

THE LIFELONG LEARNER: A PROFESSIONAL CONTINUUM

Lifelong learning should involve a systematic approach whereby doctors and other health professionals are helped to identify development needs that would enable them to do their jobs better (i.e. raise its quality) and move them towards career goals they may have (*Figure 1*). This is a laudable aim to be welcomed in the recently published NHS human resource strategy (NHS Executive, 1998). Postgraduate medical organizations are well placed to play a crucial part.

Personal development plans (PDPs) should be seen as a helpful tool in this postgraduate education process. Elements should identify the service goals to be addressed (for example, through the acquisition or development of clinical or other skills) and career aspirations, how needs could be met, the timescale for achievement, and how success will be judged. The issue of resources cannot be ignored.

The principles behind, and key components of, PDPs should be common to all NHS staff. It is their content, arrived at by joint discussions and negotiation, that will differ. Initially plans are likely to focus on what could or should be achieved perhaps within the next 3 years.

This process would be a big step in helping to foster links between clinical governance, lifelong learning and evidence-based practice, since the latter must be at the heart of many professional development initiatives.

Currently my perception is of much time and resource wasted on courses of doubtful provenance and value, with no predetermined objectives or follow-up regarding improvements in skills or competencies, let alone service or health gain. As a postgraduate dean providing funding I feel I am often supporting one of the provincial railway companies, and hotels and other organizations in the south-east of England.

LINKING EDUCATION AND TRAINING, AND QUALITY OF CARE

High quality care depends on sound education and training (GMC, 1998b). All experienced doctors have a responsibility for the personal and professional development of trainees with whom they work, as role models, teachers and supervisors. The Calman reforms to specialist training, in my view, offer the best opportunity to meet trainees' educational needs. The structures and processes are largely in place; the challenge is to equip those managing and delivering education and training to fulfil this promise. Trainees should expect:

- Educational supervision
- Clinical supervision
- Personal training objectives
- Regular review of their learning needs and plans

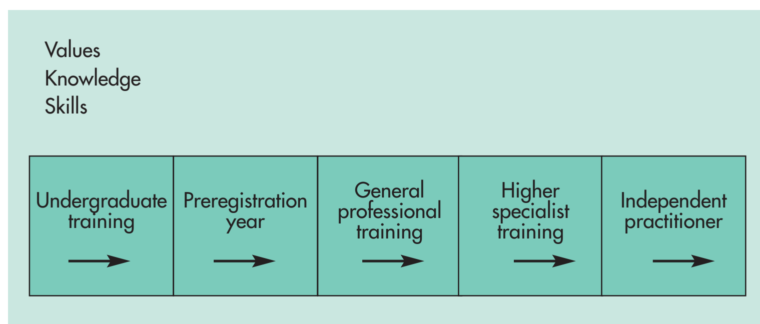

Figure 1. The lifelong learner: a professional continuum.

- Feedback on performance
- An induction programme at every new location
- Systematic clinical training, with generic and specialist components
- Access to evidence
- Access to advice and support.

Trainees must have educational and clinical supervision appropriate to their experience and which helps their personal and professional development. Their training, wherever and whenever possible, should be tailored to individual needs. They need positive and constructive negative feedback on their performance. A balance must be struck between the specialty component of training and the broader range of skills and experience needed to equip them to be effective consultants. All health professionals need access to the evidence they need to care for patients properly day and night. Trainees also need ready access to a range of advice and support.

Consultant trainers need to support and help trainees meet these aspirations. We have some way to go to reach the full application of equal opportunities principles. To learn and maximize the opportunities available, expectations must be made explicit at every stage. Service interactions are arguably the best for learning and should be exploited as fully as possible.

However, trainees have responsibilities too. They must comply with *Good Medical Practice* (GMC, 1998a), they also have to work and they must take responsibility for their own CPD. Gatrell and White (1999) have gone a long way to providing a comprehensive self driven approach.

PROFESSIONAL SELF-REGULATION AT A LOCAL LEVEL

Professional self-regulation at a local level will be an essential part of arrangements for clinical governance (Scally and Donaldson, 1998). This key element will have national approaches and statutory bodies acting in support. Local measures must be in place when it is identified that trainee doctors or established practitioners need to improve performance. Team work will be essential, as will the cooperation of individuals identified and their colleagues.

KEY POINTS

- Clinical governance is a new approach to quality with profound implications.
- Patients of the future will expect and demand high quality care.
- High quality education and training underpins high quality care.
- Doctors must become lifelong learners and evidence-based practitioners.
- Trainers and trainees have expectations and responsibilities.
- Action needs to be taken at national, local and individual levels.

THE PATIENT PERSPECTIVE

Increasing the input of patients and the public to all aspects of the service is another central government aim. This notion needs to permeate every aspect of the NHS, from the consultation (at its heart, surely the central task of medicine) outwards. Achieving this will not be easy, but the first important step is to make the commitment to do so. To engage the public more closely in clinical governance, one approach for those of us involved in (postgraduate medical) education would be to elicit patient views on how they perceive their care by doctors in training.

SO WHAT NEEDS TO HAPPEN?

While the quest for quality stimulated by clinical governance is laudable, there are considerable resource implications that need recognizing at a national level by the government.

For trusts this is another important strand in an already crowded agenda, but which will be underpinned by a statutory responsibility. It needs constructive action and interaction between health professionals and managers internally and, in the field of education and training, externally with postgraduate medical organizations and other education providers.

All doctors need to be aware of their responsibilities for the care of patients and education and training as part of CPD. Where needs are identified doctors must avail themselves of opportunities to meet those needs. The role of postgraduate medical education organizations, and part of my responsibility, is to ensure such opportunities are available.

CONCLUSIONS

Clinical governance offers a real chance to enhance the quality of patient care. It provides a coherent framework within which education and training can be directed towards this goal. HM

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