Clinical governance—watchword or buzzword?

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Abstract

In the latest reform of the National Health Service great emphasis has been placed on the achievement and maintenance of quality. Mechanisms for ensuring this are being set up under the general title of “clinical governance”. What is the meaning of this term? The metaphor behind the phrase is of navigation through stormy seas, but who guides the helmsman? Clinical ethics committees could have a part to play in these changes, provided their role is properly understood. Clinical governance is concerned with management according to an agreed set of aims. The task of ethics committees is Socratic rather than managerial. They should ask fundamental questions about the ethical norms of the services provided and give critical appraisal of the moral character of institutional policies. If these tasks are carried out then governance may become a watchword rather than just another buzzword.

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Introduction

How might clinical ethics committees (CECs), if established, relate to the new obligations imposed on National Health Service (NHS) organisations to set up and implement systems of “clinical governance”? One of the difficulties in answering this question is that it can be hard to distinguish rhetoric from substantive change in political proposals to reform the NHS. Under New Labour all things have become “new”. The NHS is no exception. We now have the “new NHS”,¹ though this phrase is in fact a deliberate echo of the historic proposals to establish the service in the postwar era. Proposals for the renewed new health service come with a whole collection of buzzwords: “partnership”, “joined up working”, “modernisation”, and—most prominent in all recent communications—“governance”.² Governance itself subdivides into three sectors: financial governance, research governance, and clinical governance. In this article I shall focus on the last of these, since the first is fairly self evident, dealing as it does with financial accountability and probity, and the second (research governance) is yet to be explained in any detail.

The question at issue in this paper is whether the concept of clinical governance has anything of substance to offer to effective ethical monitoring and support in the NHS. Is it a watchword for genuinely critical ethical reflection? Or is it merely another buzzword, a piece of trendy newspeak designed to create the illusion of innovation and reform? I cannot give any definitive answers to these questions at this stage, since the changes proposed are only just beginning to be put in place. Thus what I say is largely speculation, based only on what has been stipulated so far in government directives on the topic. I shall begin with the term “governance” itself, since this is an interesting, though largely unnoticed, metaphor; then I shall try to analyse the current proposals, in particular their stress on developing quality improvement; finally I shall discuss how, if at all, clinical governance might improve the ethical character of health care delivery.

The metaphor

The term “governance” has both a very modern and a very ancient resonance. Its modern cousin is “cybernetics”, the science of control in a computerised environment, but behind both terms lies an ancient metaphor of seafaring. The Greek root, *gubernator*, means the helmsman. It seems we are being offered an image of battling with elemental forces, of charting a course through a mighty, confusing and often frightening ocean. Both the modern and the ancient associations suggest continuous difficulty, complexity and the need for highly skilled control of the potentially chaotic. These images are at least partially seen by the advocates of clinical governance in the NHS. The chief medical officer, in an article in a primary care magazine, has reported the following comments from one group of primary care providers who are trying to implement the changes: “It feels at present as if the NHS and Primary Care, is being buffeted by a series of tidal waves . . . to us clinical governance is a means by which we can collectively preserve our core values, seize the initiative, and ride the waves”.³

We are dealing, then, with a metaphor that combines vision with control. The helmsman saves the ship from being overwhelmed by the forces of wind and wave, harnessing them instead to traverse a course ordered by the captain. Governance has no purpose without a charted course: it is merely control for its own sake. But the orders are quite useless, if there is no one with the skill to keep the

vessel on course. The demand for clinical governance combines a quest for values with a pressing need to make everyone feel part of the endeavour. It is a much more ambitious project than mere risk management, the weeding out of the most egregious miscreants. It aims for a sense of shared goals and the experience of real progress in achieving them.

The miasma of quality

What then is the shared goal, the agreed course for the good ship NHS? Here matters become distinctly hazy. The term “quality enhancement” is used, as though its meaning were self evident. But, in the absence of specification, the term is as empty as “quantity”—it refers merely to a dimension for measurement. Unless we know the nature of that being assessed and the means of defining improvement we know literally nothing about quality enhancement (or deterioration). Much of the language in government circulars seems merely rhetorical at this juncture. Take, for example, this passage from a Department of Health circular:

“The vision emphasises the need for a move to a culture of learning—an open and participative culture in which education, research and sharing of good practice thrive It reinforces the importance of multidisciplinary team working, and the need for clear accountability to and by the NHS Trust Board. It also makes the important link to the need to work with users, carers and the public.”⁴

The problem with such writing is that it deals entirely with means and not at all with ends. In this it betrays its origins in business management theory. In a business, the end or purpose is not in question: it is to maximise profit, by creating an effective and cooperative work force in order to produce a product which satisfies the consumer in terms of the trade-off between quality and price. In the manufacturing industry (and to an extent in many service industries) quality is fairly easy to define, since it is closely related to what the consumer requires for her purposes. Thus customer satisfaction is a fairly good guide to the achievement of adequate quality to sell the product. None of this can be directly applied to the work of health professionals or to the institutions within which they practise. The services provided by the NHS are entirely unrelated to questions of profit and are only partially related to consumer satisfaction. Many patients who have been badly treated by unscrupulous health professionals have been entirely satisfied, indeed grateful, since they were wholly unaware of the poor quality of the service provided. The goals to which the health service is directed relate not merely to the wants or demands of patients, but to their needs, and at times even these may be left unmet by a public service, in the interests of justice to the needier members of the community. Thus the goals are complex, not easily defined and essentially evaluative in character. They will not be met merely by having effective teamwork, though clearly this is one necessary con-

dition for their full achievement. The enhancement of quality in the NHS requires a continuing dialogue about its fundamental moral commitments and about how these are to be achieved in practice. The NHS circular describes a change in the culture of the organisation, which could certainly facilitate such a dialogue, but more is required. What is needed is a critical ethical edge to the assessments of quality. We need that spirit of fearless enquiry about fundamental assumptions represented by Socrates.

Clinical ethics committees—in search of the Socratic?

How then might the establishment of clinical ethics committees relate to the emergence of mechanisms for clinical governance? There is ample scope for confusion on this issue, and it will be vital to ensure that managers do not confuse the roles of such committees with those of the various other committees they have to establish for clinical governance. I begin this section with the official definition of clinical governance in the NHS circular, *Clinical Governance: Quality in the New NHS*:

“A framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”²

There is ample guidance in this document about how this aim is to be achieved. Clear national standards will be set by the national service frameworks and by NICE. Three national initiatives, a patient and user survey, a National Performance Framework and the Commission for Health Improvement, will monitor the delivery of these standards. At local level clinical governance arrangements will have to be put in place, with identified leadership and with an agreed baseline of current quality from which improvements must be made.

All this is admirable, and if it can be made to work throughout the NHS it should noticeably raise the standard of care and ensure greater protection of patients from inadequate services or professional malpractice. But how does it all relate to ethical support and appraisal? Misunderstandings will easily arise. For example, managers may see clinical ethics committees as part of risk management and so expect them to reduce the incidence of unethical practice. There is no prospect of this happening, even if it is a desirable or appropriate role for clinical ethics committees. Ethics committees perform a consultative, not a managerial, role in health institutions. It is unimaginable that they could, or should, seek out unethical practice and try to remedy it. Indeed, the most likely people to consult such committees are the most ethically conscientious of the professional staff. The practitioners whose practice is of concern ethically are not at all likely to submit their clinical decisions to ethical scrutiny! Moreover, at a deeper level, the task of ethical analysis and advice is not to

offer incontestable moral judgments on the decisions or practices of individual practitioners. Not infrequently there may be diverse views of the right course of action on the committee itself, and usually the task of the committee is to air the debate, leaving the individual practitioner or treatment team to reach a considered judgment on their own responsibility. Committees may help to produce more thoughtful, educated and self critical practitioners, but the end result could be an increase, not a decrease of risk to the institution from such independently minded practitioners. The search for the Socratic is often the search for the controversial, and it should not be forgotten that Socrates himself was found guilty of (educational) malpractice by an Athenian court.

Health professionals may also misunderstand the role of ethics appraisal in the new, endlessly monitored, NHS. Increasingly they may look to a clinical ethics committee as a professional haven, offering a sympathetic ear, and perhaps some conceptual weight, to their complaints that the management's or the government's "obsession" with standards and with quality assessment is impeding their ability to spend time with patients, and so is unethical. This is, again, a misunderstanding of the nature of modern ethical review. A genuinely independent committee will not support a solution which suits the practice style of one professional group, or which favours the patients of the more politically powerful specialties. Of course, the balance between delivering a service and having it adequately monitored must always be a matter of concern, especially if resources to enable both are inadequately provided. In that situation, a priority could well be to focus on patient care at the expense of management functions. But this can be only an interim solution. It cannot be an ethical aim merely to deliver a service, with no adequate checks on its quality.

So if ethics appraisal suits neither the management nor the agenda of some health professionals in clinical governance, of what relevance is it? I return to the difficulty of defining quality, discussed in the previous section. Clinical governance will eventually be based on national benchmarks, based on comparisons between institutions in their performance measured against a complex set of criteria. Some of these criteria will be evidence based and will be defined by NICE; others will be derived from the government's requirements as laid out in national service frameworks or from the recommendations of CHI. All such national criteria depend on value judgments. They are not merely "objective" in some narrow sense, and they are certainly not self evident. They entail deciding what the priorities of a national health service should be and arguing for interventions which fulfill the basic moral goals of the service. To describe a treatment as "effective", for example, entails some assumptions about what outcomes should be achieved, and since many medical treatments do not achieve only beneficial results, some balance of burdens and benefits must be calculated. Equally, the definitions

of health improvements in target-setting entail assumptions about the relative importance of interventions, which save or prolong lives and those, which improve quality of life.

The "product" of the NHS is incredibly complex and assessments of how it is to be achieved must be the outcome of sustained debate, involving a wide range of people within and outside its institutions. I regard a clinical ethics committee as a natural location for, or initiator of, such debates at the local level. Since every trust and health authority must produce its own clinical governance documents, including a local benchmarking that will determine the nature of the improvements required, I would suggest that, where clinical ethics committees exist, they should be invited to comment on the ethical assumptions implicit in the quality improvement plans endorsed by the local institutions.

In conclusion, we should not underestimate the importance of establishing clinical ethics committees within the institutions of the "new" NHS. I have argued that their relationship to clinical governance is indirect and that they must not be seen as merely tools of the new emphasis on quality improvement, or as bastions of the defenders of professional power. They can indirectly improve the quality of care by providing support to clinicians and managers as they face difficult clinical decisions; and they could help to create the kind of reflective and self critical culture within the NHS which will be essential for clinical governance to be a genuine, rather than a cosmetic, change. To achieve this they must be independent of both management and clinical staff, yet carry authority with both—no easy task!

But, finally, ethics committees themselves should not be exempt from the sustained and planned scrutiny of clinical governance. Do they provide a service that meets national standards of professional ethical consultancy? How do they audit their own performance? And what measures are they taking to remedy deficiencies in their own procedures? If—to return one last time to the maritime image of governance—they see themselves as part of the good ship NHS as it tries to chart its somewhat perilous voyage, we need to know that they are professional and trustworthy members of the crew.

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