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Clinical governance: philosophy, rhetoric and repression

Michael Loughlin

Introduction

Huge claims have been made on behalf of clinical governance. According to the Department of Health (1997) this 'central plank' of government policy will transform the health service, putting 'quality' at its 'heart'. Its adoption will 'assure and improve clinical standards' throughout the service by providing that 'good practice is rapidly disseminated and systems are in place to ensure constructive improvements in clinical care'.

Professor Liam Donaldson, the Chief Medical Officer and someone closely associated with the development of clinical governance in the UK, describes the document in which these claims are made as 'a watershed in the approach to quality in the NHS' (Donaldson 1999 p7) and states that:

'This is probably the most important development in the NHS for thirty years and will have profound implications for every hospital and primary care service as well as individual doctors and other health professionals.' (*op. cit.*)

According to Donaldson:

'The introduction of clinical governance, aimed as it is at improving the quality of clinical care at all levels of healthcare provision, is by far the most ambitious quality initiative that will ever have been implemented in the NHS.'

(Scally & Donaldson 1998 p62)

What is apparently novel about this initiative is that it will not only 'maintain standards' but will also 'continuously improve quality' (*op. cit.*) by promoting 'accountability', 'the widespread adoption of the principles and methods of continuous quality improvement' (*ibid. p62*), 'excellence' and practice based on 'evidence' rather than 'opinion alone' (*ibid. p63*). Other enthusiasts for clinical governance describe it as 'a breathtaking idea, whose simplicity belies its complexity' (Hill 1999 p596) which will foster 'clinical effectiveness', 'the pursuit of excellence in clinical care' and 'the proper use of public money' (Morrison 1999 p163).

flow diagrams, pictures of temples and the like that are offered in place of any clear account of the true substance of what is being proposed. If to wonder about this is to have become infected with cynicism, then let us be clear about the source of the infection. Philosophy has been compared with a ‘knife’ (Pirsig 1988 p77) and a method of ‘intellectual and moral self-defence’ (Loughlin M 2000 p5). Like it or not, we need to cut through the nonsense and to examine directly whatever lies behind it, if our hearts and minds are to survive the corrupting influences of our age.

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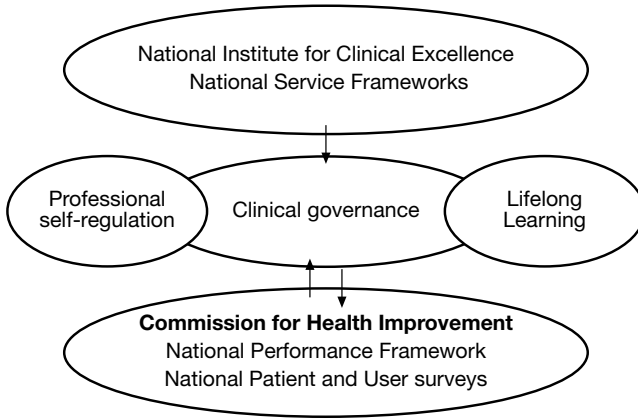


Figure 9.4 Principle relationships of clinical governance showing its central role position – the official version

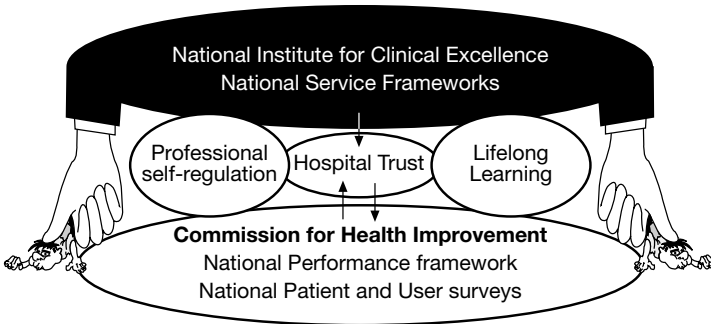


Figure 9.5 The restricting effects of central control. Compare with Figure 9.4

The new Health Bill giving legal empowerment to this initiative states that there is a statutory duty of quality that balances the National Health Service’s duties in financial areas. Clinical governance and financial governance are now on an equal footing. The financial standard of an annual balanced budget, which trusts are expected to work to, is an internationally recognised standard. What is the equivalent standard for clinical practice? It seems to me that it is certainly not a 12-month waiting list for cardiac surgery. Where, then, does this question lead us? In setting standards one has to accept that there is no such thing as an absolute standard