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Clinical Governance and the Development of a New Professionalism in Medicine: Educational Implications

GEORGE TAYLOR, EdD, FRCGP

Postgraduate Institute, Newcastle Medical School, Newcastle on Tyne, UK

ABSTRACT *This paper discusses the need for doctors to further develop the use of professional learning in the workplace as an effective method of coping with change. It uses the recent introduction into the UK, by the government, of clinical governance as an example of how professional learning can help doctors both cope with this imposed change and recognise their ongoing need to undertake a different and changing relationship with society, and it lays the foundations for coping with further change throughout their careers.*

KEYWORDS *Clinical governance, change, professionalism, learning.*

> We are what we repeatedly do. Excellence is then not an act but a habit. (Aristotle)

Introduction: What Is Clinical Governance?

The National Health Service (NHS) in the UK has a history of continuing change. In 1997 the concept of clinical governance was introduced into the NHS. The overall aim of this is the development of systems for ensuring quality in health care. Sam Galbraith, a Scottish Health Minister, defined it succinctly as ''corporate accountability for clinical practice'' (RCGP, 1999a).

Address for correspondence: Postgraduate Institute, Newcastle Medical School, Newcastle on Tyne NE2 4AB, UK. Tel: +44(0)191 222 6766. Fax: +44(0)191 232 6721.
E-mail: g.b.taylor@ncl.ac.uk

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In 1999 Buetlow and Rowland said:

> Clinical governance aims to bring together managerial, organisational, and clinical approaches to improving quality of care. If successful it will define a new type of professionalism for the next century. (p. 184)

Professionalism

Professionalism would thus seem to be a major component of clinical governance. A traditional definition of being a professional would include the ensuring by doctors that they are keeping up to date, are maintaining and developing standards, and that as a group doctors are protecting the public from malpractice. All of these factors impact on and influence care.

What being a professional means has however changed over time. In the 1970s Johnson (1972) defined professions as having:

- a professional knowledge base;
- a social control of expertise; and
- a wish to protect clients against incompetence and exploitation.

To facilitate this, professions had codes of conduct, an orientation to service and an emphasis on moral probity. The professions also carried out careful recruitment and training, had codes of ethics and had committees to deal with breaches (Rueschemeyer, 1983). Through these factors professions gained status and privilege.

One of the most interesting developments in the last quarter of a century has been the move by society to question professional rights and even be cynical about them. No longer can professionals expect that:

> they exchange competence and integrity against the trust of the client and community, relative freedom from lay supervision and interference, protection against unqualified competition as well as substantial remuneration and higher social status. (Rueschemeyer, 1983, p. 41)

Now professional values may be viewed as patronising, and their conduct as self-serving.

This change in society has lead to a greater political involvement in the affairs of the professions and a greater wish to be involved in the regulation of professional work. This is supported by exhortations for efficiency, effectiveness, economy, responsiveness and quality (Eraut, 1994).

Eraut (1994) identified the following components to professionalism as:

- a moral commitment to serve the clients interests;
- the discipline to self-monitor and review personal practice;
- the will to expand one's personal repertoire, and reflect on one's experience;
- to contribute to your organisation; and
- to reflect on and contribute to the profession's changing role in society.

Sir Donald Irvine has recently spoken of a new professionalism (Irvine, 1999) involving:

- clear professional values;
- explicit standards;
- collective as well as personal responsibility for standards of practice;
- local medical regulation based on teams;
- systematic evidence of keeping up to date and of adequate performance;
- effective systems for dealing with dysfunctional doctors; and
- the modernisation of the GMC.

Irvine is being more explicit about traditional components of being a professional, the collective responsibility for standards, about the standards themselves, and the profession's methods of dealing with dysfunctional professionals. These components are not new, merely more clearly enunciated.

What is also made more explicit is the requirement for evidence of adequate performance rather than the traditional expectation that a professional would provide, as part of their professionalism, a more than adequate standard of care.

If the components of professionalism in Eraut's definition are combined with Irvine's and were present in most doctors, quality would not be an issue. Professionals however have to recognise the need for more explicit standards and having a more open approach to society. The individual professional, like all professions, does not like to be seen as a ''whistle blower'' and does not like to be seen to be questioning another professional's work. This approach has to, and is, changing, and education has a major role to play in its development.

Education, Professionalism and Clinical Governance

From the first day of their training undergraduate students must be helped to develop within themselves the ability to reflect on their work. This can be achieved by their carrying out reviews of their work, both in formal ways such as by the use of clinical audit, and informally by daily review of work, as it takes place. That juniors model on their seniors is well recognised. Undergraduates

must observe their seniors constantly reflecting on their practice. The skills of both ''reflecting in action'', as care is provided, and ''reflecting on action'', after events have taken place, are both identified as vital for effective professional practice (Eraut, 1994). Whilst professionals develop the skill of being able to apply judgement quickly in situations and undergraduates need to learn this vital skill, undergraduates also need to hear their seniors say ''I don't know'' more often. They also need to hear them then go on to discuss how they will find out the answer to their problem. Asking ''why'' something has happened in a constructive rather than a punitive way has also to be developed further in medicine.

Doctors as a group have been said to need to develop what has been called ''a personal moral imperative'' for quality (RCGP, 1999b). This has to be based on

- the stamina to produce quality every day;
- awareness of professional responsibilities;
- insight into the effects of care on patients; and
- recognition of the limits of their personal skills (RCGP, 2000).

Eraut (Eraut *et al.*, 1997) has recognised that most professional learning takes place in the workplace and is facilitated by contact with our work colleagues. Both undergraduates and graduates must therefore maximise these opportunities. The move from ''knowing that'' to ''knowing how'' that is the translation of our academic, factual, knowledge into professional or useful applied knowledge is an everyday requirement of a developing professional. Professional responsibility both for personal development and also development of their organisation is thus facilitated by their recognition of the sources of learning provided by their daily work.

In UK general practice this learning and development can be helped by the use of practice professional development planning (PPDP) (Chief Medical Officer, 1998). This is a method of facilitating not only individuals' personal development but also the development of both the local health organisation and the National Health Service.

Those developing PPDPs can identify educational needs by a number of simple techniques: by keeping a personal log of learning needs identified during routine work (Jelley, 2000), by critical case analysis (Pringle *et al.*, 1995), and by carrying out clinical audit. Critical case analysis, sometimes called significant event audit, involves a health care team in the structured review of situations that have either gone well or have not, in order to identify the key factors involved. The aim is not to ''name and shame'' but to identify that which can be replicated to the value of all, or things that need to be avoided in future. The overall aim is that those involved learn practical and useful information, helpful in their future working.

Alongside this, whilst recognising that the relationship with patients has changed and hopefully developed in recent years, doctors must also recognise, value and use their contacts with patients as an educational resource (Stacy & Spencer, 1999). Patient contact not only helps us recognise where there are gaps in our knowledge and skills at a clinical level, but can also be used to provide feedback on our ability to communicate effectively. These learning needs can be identified informally during our consultations and noted in a log (Eve, 1995) or can be collected in a more formal way by the video taping and analysis of consultations (Pendleton *et al.*, 1984). Surveys of patients can give a more quantitative feedback on what patients perceive as strengths and weaknesses in doctors practice (Baker, 1997). All of the above methods of personal education involve the use of components of adult learning theory (Brookfield, 1986). This theory proposes that we learn best when topics are related to our daily work and we are able to use what we learn quickly and with immediate benefit to ourselves.

Clinical governance lays the foundations of ensuring high quality care within the National Health Service based on skilled professionals, and systems which allow all involved professionals, patients and National Health Service managers, to be sure that an acceptable level of care is being achieved. Leadership, change management skills and the ability of professionals to respond to the ever-changing society we live in have been identified as key requirements for its development (Taylor, 2000). However, the recognition, valuing, and using of those situations where professional learning can take place are also a major developmental need for clinical governance and have to be developed more in medicine. This professional learning has also to be recognised as part of a process of continuing professional development that is lifelong.

Conclusion

The expectations of a society of professionals and of the NHS will continue to change and develop as health care cannot be cut off from the real world, which is itself constantly changing. Change, despite the wishes of most, is never linear or predictable (Stacey, 1996). We all have to develop methods of coping with change to survive. A new concept like clinical governance, which demands both the development of a new style of professionalism and a changed relationship with patients and managers, may be found to be difficult for many doctors. If, however, professional development and education recognises and values what our professional colleagues and patients can bring to our own development, and if informal learning is valued as highly as formal educational provision is at present, then by helping doctors to recognise and use informal educational methods in the workplace, they will be more able to maintain their professional knowledge and skills throughout their careers. They will also have developed effective mechanisms on which to base their ability to cope with future change.

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