Clinical governance: many fancies, very few facts

Pier Mannuccio Mannucci

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Any consideration about the type and degree of involvement of medical doctors in clinical governance must stem from a clear understanding and agreement on the meaning of this term, which is often used (and abused) in several different ways. There is little doubt that confusion and lack of agreement on what clinical governance truly means has substantially contributed to procrastinate the effective implementation of this model, owing to the more or less hidden reluctance of health care providers and managers to involve medical doctors with a truly active role, particularly for matters and issues that pertain to health technology assessment.

There are some lines of thoughts that chose to limit the definition and goals of clinical governance to the optimal application by clinicians of a series of instruments stemming from evidence-based medicine in patient care. At most, this narrow interpretation of clinical governance foresees the involvement of doctors in the active development and application of systematic reviews, meta-analysis and resulting guidelines. According to these thoughts, clinical governance is seen as a problem of optimal delivery of instruments and methodologies, and perhaps of their continuous improvement, but the true and actual involvement of physicians in governance and health technology assessment is indeed overlooked.

This approach has many limitations and pitfalls, because it fails to put physicians in charge of the effective management of the health care institutions where they do practice. In particular, it fails to tackle the issue of their engagement and responsibility in sharing the actual strategic

choices of the administrators of such institutions. For instance, doctors should be truly involved in issues pertaining to the quality of health care delivery, on how this should be innovated, and the development of professional competences and technological progress. The ultimate goal is to value medical doctors for their clinical competence and proficiency, after having aimed in the recent past to transform them into managers first and then into epidemiologists and methodologists on the wave of evidence-based medicine. It is essential to have clearly in mind that the ultimate goal of the medical engagement in governance is the actual and effective improvement of health care delivery to consumers through efficacious interventions agreed upon between the two parties of health care providers, leading to a significant and substantial progress in terms of safety, efficacy and costs. Hence, clinical governance is an issue of policy rather than of technical instruments.

If clinical governance is defined and interpreted as the full operational involvement of medical doctors in the strategic development of health care institutions (typically, but not exclusively, hospitals), it is also necessary that they participate actively in the process of clinical governance, through the factual demonstration that they are truly ready to take an active role in the evaluation and improvement of their own professional quality. With this as background, a learned scientific organization such as the Italian Society of Internal Medicine (SIMI) launched a few years ago a program of quality control and improvement of professional practice and proficiency run by the members of its constituency. The initiative was and still is fully voluntary, and has the goal to evaluate clinical proceedings and their implementation in internal medicine wards through an audit carried out by an independent team made of peer internists specially trained to acquire competence in the field of quality control. The audit has the goal of ultimately

P. M. Mannucci (✉)
Scientific Direction, IRCCS Ca' Granda Maggiore Policlinico
Hospital Foundation, Milan, Italy
e-mail: pmmannucci@libero.it

providing the participating medical units with a certification of professional accreditation awarded by SIMI, if a defined threshold of performances is achieved. This approach shows that internists are prepared to be challenged by their peers in order to evaluate their degree of adherence to a set of organizational, diagnostic and therapeutic standards based upon evidence. This innovative process of accreditation is completely different from, but not incompatible with, the institutional accreditation required by health care payers (in Italy, for instance, the Regions), and from those of ISO 9000 and Joint Commission.

In this issue of the Internal and Emergency Medicine, Vanoli and his team of colleagues [1], the executive initiators of the ongoing program of SIMI professional accreditation, present with some details their blueprint, and make a preliminary analysis of the results of the professional accreditation process of a few internal medicine wards in Italy. Their analysis is based upon the comparison of the concordance, for a large set of pre-established standards of definite clinical relevance, between the self-evaluation

made by the participating medical wards and the external evaluation made by a team of peer internists. I am convinced that this initiative stands as a milestone in the process of fostering clinical governance, because it shows that medical doctors are prepared to be challenged and to take an active role in order to improve their clinical practice. The SIMI program of professional accreditation is in its infancy and is still ongoing. Yet, it already represents an example of the role that stakeholders, in general, and internists, in particular, should take to truly implement clinical governance.

Conflict of interest None.

Reference

1. Vanoli M, Traisci G, Franchini A, Benetti G, Serra P, Monti MA (2011) A program of professional accreditation of hospital wards by the Italian Society of Internal Medicine (SIMI): self- versus peer-evaluation. *Intern Emerg Med*. doi:[10.1007/s11739-011-0684-6](https://doi.org/10.1007/s11739-011-0684-6)