CLINICAL GOVERNANCE – AN AWARENESS

Dr. Stephen Bolsin (1995), an anesthetist exposed an unacceptable high mortality in pediatric cardiac surgery at Bristol Royal Infirmary. An instant need was felt by the National Health Services (NHS) of the UK to develop a process which would standardize and continuously seek improvement in the quality of health care and fix the responsibility and accountability for such standards. This process was named clinical governance akin to corporate governance.

Clinical governance is defined as the "system through which NHS organizations are accountable for continuously monitoring and improving the quality of their care and services and safeguard high standards of care and services" *NHS quality improvement Scotland 2005*.

In 1999 the U.K. NHS trust boards assumed statutory responsibility for quality care. Hither to the NHS only insured financial management and acceptable level of patient safety. The idea of clinical governance has found supporters in Hong Kong and Malta as well.

The clinical governance is composed of at least six elements. **Education and training** – of health personnel through conferences and CMEs. The official organs are continuous professional development of doctors (CPD). PG education allowance for GP (PGEAGP) post registration education practice for nurses (PREP). Whatever is learnt in training during acquiring qualification gradually becomes out of date. Hence, a need for continuous training. The fund of such trainings is provided by MADEL and NMET funding streams. **Clinical Audit** – It is the review and measurement of clinical performance against agreed standards. Its components are structure (quality of the organization and health providers), process (actual treatment) and the outcome (result of the treatment). The idea of the audit is to improve the quality of the patients care. **Clinical effectiveness** – It measures the effectiveness of a particular treatment or intervention. The safety of such interventions and its value for money should minutely be assessed. **Risk management** – Health care is a risky business. There are risks to the doctors, to the patients and to the provider organization. All these risks have to be minimized as a part of the quality assurance program. The risk to the patients can be minimized by adhering to the statutory regulations, critical event audits and learning from the complaints. The risk to the doctors and the paramedical staff can be ensured through immunizing against infectious disease and by understanding the safety procedures. **Information management** – Patient's records and use of wide range of information obtained within the health care system will help determine the system's effectiveness in dealing with the health problems, defining priorities and allocating resources to improve health outcomes. **Openness** - Transparency in the services is an essential part of the quality assurance. Substandard and poor performances often thrive behind closed doors. The system should be open to public scrutiny, of course respecting the confidentiality clause.

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In view of the generaL disstaisfaction expressed (sometimes violently) by patients causing problems to the hospital, the editor feels that consolidated clinical governance could be a panacea for such troubles. Hence, to emphasize the editorial is repeated (2012;10(2)).