Clinical governance and genitourinary medicine

R N T Thin

Introduction
This paper will briefly outline Harrison's contribution to venereology or genitourinary (GU) medicine, and show how his principles of good practice fulfils many of the principles of clinical governance. The paper will then outline some general principles of clinical governance and indicate how they relate to GU medicine.

Colonel LW Harrison, CB DSO MBCHB FRCPE
Harrison's early career was in the Royal Army Medical Corps. Here, he undertook general duties (general practice), clinical venereology, and laboratory work in which he demonstrated a flair for research and development. In the first world war he showed enormous organisational and administrative ability by setting up a venereology service for the British Army in north west Europe based on a hospital with 3000 beds. By the end of the war he was adviser in venereology to the War Office.

He retired from the army in 1919 at the age of 43 years. The same year he was appointed adviser in venereology to the Ministry of Health and set up a model clinic at St Thomas's Hospital in London. His principles for the design of a clinic were:

(1) Waiting periods were to be kept to a minimum
(2) Patients should be examined in the greatest possible privacy and never in the presence of other patients
(3) Ease of access of staff to patients
(4) The distances covered by staff and the time occupied in obtaining drugs and instruments should be kept to a minimum.

These principles still apply. Waiting periods were minimised by keeping his clinic open for 12 hours a day on weekdays and for nearly as long on Saturdays and Sundays.

He had written guidelines for the content of case notes, including the source of infection, and guidelines for treatment. He reviewed the case notes of all patients for quality and the relation between the clinical features and laboratory results. He discussed any problems with the doctors concerned. Thus, in his clinical practice he fulfilled three aspects of clinical governance—namely written guidelines, audit, and (informal) appraisal. He was an enthusiastic teacher and was one of the first to introduce cine films into undergraduate teaching. He held a weekly clinical meeting for clinic staff and students in which he discussed selected cases. He was a founder member of the Medical Society for the Study of Venereal Diseases (MSSVD) and took an active part in its meetings. He was a founder editor of the society's journal and held office for 17 years. He made many contributions to the literature. Thus, he was a strong supporter of what he would have regarded as postgraduate education, now embraced by continuing medical education (CME) and continuing professional development (CPD). As adviser to the Ministry of Health at a time when many towns and cities were setting up clinics in accordance with the Public Health (Venereal Diseases) Regulations 1916, he visited many departments and provided advice—a form of peer review. He therefore saw clinical excellence arising from written guidelines, audit, appraisal, CME/CPD, and peer review. If one changes the terminology, Harrison's view of good practice or clinical excellence fulfilled many facets of the concept of clinical governance. Fuller details of Harrison's life were described by Mr Ambrose King in the first Harrison Lecture.

Early in 1919 Harrison was invited to Edinburgh to become lecturer in venereal diseases and to set up a clinic. He did not take up this appointment as he accepted the post of adviser in venereology to the Ministry of Health in London, but he maintained contact with Edinburgh. Harrison's work caught the attention and imagination of senior figures in Edinburgh medicine. Harrison was elected to the membership of the Royal College of Physicians of Edinburgh in 1919, and in 1924 he became a fellow of the college. On both occasions he was supported by senior fellows at the very top of the college hierarchy (Iain Milne, college librarian, personal communications) and the leaders in medicine at Edinburgh where clinical excellence has always been held in high regard.

Clinical governance
By the mid 1990s, the National Health Service in the United Kingdom had become more financially driven than ever before, with chief executives of trusts having financial control as their prime responsibility. Around this time there were a number of well publicised clinical failures. Towards the end of the decade, the government of the day decided to change the emphasis to the quality of clinical care. Various methods of monitoring clinical standards, such as clinical guidelines, audit, and model job descriptions were in place, but were not coordinated and did not work well. The concept of clinical governance was introduced to draw these together and provide a focus for raising the quality of care. Clinical governance provides a system or framework for many
activities to facilitate continuous improvement in quality of service, and to safeguard high standards of care by creating an environment and culture in which excellence will flourish. There are thus two elements—a mechanistic element of systems designed to deliver high quality care, supported by a philosophy in which every member of staff strives for quality. Many of the activities encompassed by the concept of clinical governance are local. To emphasise its importance, the final responsibility for quality is placed with the chief executive of every NHS organisation though its delivery is delegated to a senior clinician, often the medical director. Clinical governance is overseen by a subcommittee of the board, to work, there must be ownership by all staff.

The three main principles underpinning clinical governance are demonstrable:

1. Clear standards of service
2. Dependable local delivery

Many activities are required to fulfil these principles and clinical governance is at the centre, coordinating and drawing them together. Some of the activities are long established such as audit, while some new organisations have been set up such as the National Institute for Clinical Excellence (NICE), and some established processes further developed such as professional self regulation and CME/CPD. The different activities are shown in figure 1. Though it was foreseen that many of the processes would take time to develop their full potential, early in 2001 many were established to varying degrees and will be considered in turn.

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE
The National Institute for Clinical Excellence (NICE) was set up to appraise new and existing health technologies or interventions, to develop clinical guidelines, and to promote their audit. NICE has taken over the management of the four national confidential inquiries. It has set up six collaborating centres to take forward multidisciplinary development of guidelines; GU medicine is a participant in the Collaborating Centre for Women and Children. In addition, GU medicine has demonstrated its quality standards for service provision by submitting its national management guidelines, which are currently under revision; these provide standards against which clinics can audit their practice. The Association for GU Medicine (AGUM) has also produced standards and guidance for other aspects of clinical activity, and it is likely that in future more standards and guidelines will be needed. For a number of areas of clinical activity, national service frameworks (NSFs) have been drawn up which describe standards for service delivery, but as yet none of these involve GU medicine.

COMMISSION FOR HEALTH IMPROVEMENT
Another new organisation is the Commission for Health Improvement (CHI). This body’s role is to monitor delivery of service by routinely reviewing every organisation every 4 years, to undertake special investigations when something has gone seriously wrong, to conduct studies of NSFs, and provide leadership to promote best practice. The role of GU medicine is to take part when the commission reviews trusts.

PATIENT AND PUBLIC INVOLVEMENT
The NHS has long had lay (namely, public) representation at the board level of its organisations. A lay representative is required on clinical standards and governance committees. Lay people are mandatory on research ethics committees which should not meet unless these members are present. The emphasis now is that the patient must be at the centre of NHS activity and that the public should have much greater input to the NHS at all levels. Patients and public must therefore be involved in many aspects of clinical governance. As well as helping to plan and monitor services, patients, users, carers, and the public should be involved in activities such as audit, planning research, and sitting on research and development committees.

Patients now expect to be involved in making decisions about their care and this is well recognised in GU medicine. Human immunodeficiency virus (HIV) units have encouraged patients and carers to discuss provision of services informally and through patient satisfaction surveys. Some HIV clinics have user groups and these could provide participants for focus groups to discuss aspects of service provision. More use could be made of HIV and other community based groups. Some HIV clinics have open evenings and these could be a focus for more user liaison. There has been less patient participation in sexually transmitted infection (STI) clinics and more is needed. Most STI clinics undertake patient satisfaction surveys and these could be expanded to include accompanying people. In depth interviews could be undertaken with some attendees to explore problems like access. Open evenings could be held for STI patients; there is probably more scope for involving these patients than is recognised. Patients taking part in drug trials usually cooperate very enthusiastically and those with warts may be frequent attendees; these patients might form a nucleus.
The third activity is peer review where a department or service is reviewed by a group of specialists in the same field but working in other trusts. This concept is supported by the Royal College of Physicians and has been well developed in other specialties. Hitherto, because of financial constraints, it has been invoked in GU medicine only when services have had problems. The Association for GU Medicine is taking forward discussions to develop a rolling programme of visits.

Though these activities may appear daunting at first sight, they are common in many large organisations and are helpful to the organisation and to individual staff members.

The Association for GU Medicine is looking at ways to support colleagues, especially single handed consultants and those in non-consultant career grades—for example, in preparing for appraisal and peer review. Peer review will assist in resolving problems that cannot be cleared up during appraisal, and AGUM hopes to be able to offer support to help colleagues and services. If problems cannot be resolved during appraisal and peer review, a GU medicine support review could be requested by trusts before they consider calling in the Royal College of Physicians who also offer clinical service reviews or the Commission for Health Improvement. It is hoped that by these processes the specialty will be able to help to resolve problems at an early stage.

LIFELONG LEARNING

CME has long been recognised as vital to maintain and enhance clinical standards. In the past doctors often took part in postgraduate education in an unstructured manner with variable benefit to their practice. Now CME/CPD and personal development must relate to the needs of the individual and the organisation.

For the past 5 years there has been a voluntary system of registration and notification of CME/CPD activities monitored by the royal colleges. In 2001 a more formal scheme was introduced. In planning CME/CPD, the physician’s clinical and other activities need to be considered including future aspirations and the need to obtain the necessary credits.

RISK AVOIDANCE AND RISK MANAGEMENT

In 2000 it was realised that in the NHS as a whole there were more untoward incidents affecting patients than previously recognised. Risk avoidance and risk management assist in their reduction. Many of the activities already considered contribute to risk avoidance and risk management. Other processes, which apply to all healthcare workers, include the ability to change practice when this is needed, something doctors sometimes find difficult. All healthcare workers need to be able to recognise and know what to do when things go wrong in their own practice and that of colleagues. Systems are required for incident and near miss reporting, complaints procedures need to be seen to lead to change and, when things do go wrong, organisations need to move from a “blame culture” to a learning and training culture.
Many specialties are developing rolling programmes of external
Colleagues, especially single handed consultants, may benefit from
The patient must be at the centre of NHS activity and more
discussion with users and the public may indicate ways to improve
services

Clinical governance coordinates activities that improve quality.
When Harrison established venereology/genitourinary medicine,
his principles of good practice such as guidelines, internal audit
and (informal) appraisal fulfil modern clinical governance

The specialty must guard against abuses.
In many respects GU medicine has been abreast or ahead of the developments outlined
and takes pride in this. The specialty was founded on an ethos of multidisciplinary team
working. Though clinical governance is a local
matter, GU medicine already has many sys-
tems in place that can be applied locally. There
is a tradition of guidelines for clinical manage-
ment which is being maintained and these pro-
vide clear standards. Monitoring delivery is
well established with internal departmental
audit, multidisciplinary trust audits, and re-
gional GU medicine audits. The specialty has
set in train mechanisms to work with trusts on
professional self regulation and to provide sup-
port for colleagues in their job plans and
appraisal. Clinics already have many systems in
place for risk avoidance and risk management;
these must be carefully monitored so that con-
fidentiality is maintained but not abused.
Peer review must be worked up into a system
respected by trusts and the specialty, with the
option of additional support reviews if these
will assist in the early resolution of difficulties.
Postgraduate training is adapting to provide
CME/CPD, and the specialty’s leaders will
need to continue to be sensitive to changing
needs.

Conclusion
Harrison set up the specialty on a firm founda-
tion of clinical excellence that fulfils many of the latest requirements. He would have been
thrilled to see how the specialty has broadened
and would have applauded the drive for excel-
ence. However, he might have been concerned
over the burgeoning literature on clinical
governance, reminded us that the pursuit is
excellence of clinical care for the patient, and
that clinical governance must not become an
end in itself. The bottom line must always be;
is clinical care improving?

This paper is based on the Harrison Lecture presented at the
Spring Meeting of the Medical Society for the Study of Venereal
Diseases in May 2001 at Belfast.

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