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Original Research

Consultants' attitudes to clinical governance: Barriers and incentives to engagement

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Summary *Objective:* To explore medical specialists' attitudes to clinical governance in acute hospitals and factors influencing these attitudes.
Methods: A semi-structured interview study with a purposeful sample of 24 medical specialists from two contrasting hospitals. Hospital A had a low level of consultant involvement in quality improvement initiatives and Hospital B had higher levels of engagement.
Results: Specialists from both hospitals acknowledged that quality improvement was a major part of their role. Among specialists from Hospital A, the lack of a commonly held focus on quality-improvement, poor inter-professional relationships and little clinical engagement in management were the main factors generating negative attitudes towards clinical governance. Effective communication of the hospital's goal of continuous quality improvement to all staff groups, a sense of being able to get issues affecting the quality of care heard by senior management, and a perception that there were clear structures and processes to support clinical governance, were factors that resulted in a more positive attitude to clinical governance among specialists in Hospital B. Specialists from both hospitals identified lack of time across all professional groups and availability of accurate data as barriers to involvement in clinical governance activities.
Conclusion: The cultural context, level of technical support available, ability to communicate clear goals and strategies and the presence of structures to support delivery, all contribute to shaping specialists' attitudes to clinical governance and in turn influence levels of engagement and ultimately the success of quality improvement initiatives.

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Introduction

Reforming how health care is organized and monitored has become a political imperative in most industrialized countries owing to the growing costs of such care, the lack of proven effectiveness of many healthcare interventions and concerns related to the medical professions' ability to ensure accountability among its members.[1] Seven years ago, the English Department of Health introduced a strategy to improve quality of healthcare services.[2] 'Clinical governance' was identified as the mechanism to systematically improve standards of clinical care. Early guidance[3] identified its components: evidence-based practice, audit, risk management, mechanisms to monitor the outcomes of care, lifelong learning among clinicians and systems for managing poor performance. Healthcare providers were required to identify a clinician at board level with responsibility for clinical governance, supported by a board-level clinical governance committee.

Initial studies among managers and clinicians revealed some scepticism, especially as some components, such as clinical audit, were already perceived as having a limited effect on quality.[4–6] Key barriers to successful implementation were identified: lack of time, staff support and financial resources and issues related to organizational culture.[7] In 2002, a survey of over 1000 Trust (National Health Service provider) managers reported progress in establishing clinical governance structures and processes, including at board level, but less evidence of coherent planning or of effect on clinical practice.[8]

Involvement of physicians at strategic and operational levels is widely viewed as essential for the success of quality improvement initiatives.[9,10] However, scepticism and resistance to these initiatives has been shown to be widespread among this group of professionals.[11] Research points to a training that inculcates strong professional pride and individualism,[10–12] the power and control that physicians command,[13] a culture heavily influenced by peers and collegial processes,[14] and experience of earlier initiatives[15] as reasons for these negative attitudes and resulting lack of involvement. In contrast, healthcare organizations that have been successful in implementing quality improvement programmes highlight the importance of active involvement of doctors and point to factors such as effective clinical and managerial leadership, preservation of clinician autonomy, support for training, and peer pressure as important in changing attitudes and increasing commitment.[10,16,17] The situation is, however, dynamic as norms evolve in society and within the health professions. It remains important to understand doctors' attitudes to clinical governance in different settings and contexts to illuminate why and how interventions succeed or fail, and to identify interventions that are more likely to succeed.[18] In this paper, we describe attitudes to clinical governance in two neighbouring acute healthcare providers in South East England. In one, senior managers felt that many senior physicians (consultants) had negative attitudes to clinical governance and found it difficult to increase involvement in quality improvement activities (Hospital A). In the second, consultants were felt to have a more positive attitude and were more engaged with management (Hospital B).

Method

Interviews were carried out between September 2004 and January 2005 in two acute hospitals in South East England. The study was initiated by managers in Hospital A, who sought to understand the challenges they faced. In subsequent discussions, it was agreed that it would be important to compare Hospital A's experience with another hospital in which clinical governance was considered to be successfully embedded. Hospital A was established in 2001 after the merger of two smaller hospitals. It had 1500 beds spread across several main hospital sites, over 100 000 admissions per year and 6000 staff. Hospital B had 500 beds, 30 000 admissions a year, 1600 staff and had been based on a single site for over a decade.

A purposeful sample of 30 consultants (18 from Hospital A and 12 from Hospital B) was chosen to reflect differing levels of involvement in formal clinical governance activities, a range of specialties and differing lengths of employment. All participants were initially contacted about the project either by the executive lead for clinical governance (Hospital A) or the medical director (Hospital B). Three consultants at each hospital declined to take part.

Face-to-face, semi-structured interviews were undertaken by HH. After initial discussions with hospital management at Hospital A, which had a history of relationship difficulties between management and clinicians, it was decided that contemporaneous note-taking rather than tape recording would be used to capture information, as this method was more likely to make consultants feel comfortable about sharing their attitudes. The interviews were piloted and guided by a topic guide covering the purpose of clinical governance, barriers