DOI: 10.1590/1413-81232015208.11492014

The Polisemy of Clinical Governance: a review of literature

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Abstract *The article aims to explore the concept of clinical management, with a view towards understanding the diverse meanings that could be attributed to that expression. This discussion can contribute to the planning and organization of health services geared to the management of clinical practices, as well as to set forth principles to draft actions in that field. Methodologically, the study consists of a qualitative literature review, using keywords of the Virtual Health Library (VHL). In terms of results, seven topics stand out that synthesize the analysis of sources: management, quality promotion, clinical monitoring or auditing, education, responsibility or accountability, safety in care and a systemic dimension. The conclusion is that the variation of meanings relates to the way in which the authors of the studies reviewed express or unfold the structuring conceptual components broadly accepted as clinical governance. What we observe is a lack of a greater focus on discussions regarding planning and policies relating to clinical governance.*

Key words *Clinical governance, Management, Clinical practice*

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Introduction

In the contemporary worldwide scenario, publicas well as private health systems face challenges such as the insufficient response to the health needs of people or populations, and the ever-growing cost, with low productivity and inconstant quality. As health care systems are organized to respond to the health needs of people and populations, their management and the organization of care should reflect the principles and the logic through which societies explain and intervene in the health-disease process[1,2].

In this sense, Foucault emphasizes the biopolitical component of management and makes a contraposition to "scientificity" of the standardization of the health of people and societies, upon considering that the *biological reflects on the political*[3].

The standardization logic, associated to cost cutting and to financial results gave place, in the 1980s, to "*managed care*" in the United States. Upon aiming at economic-financial results in health management, this model began to regulate the activity of professionals, especially physicians, annulling their autonomy through the regulation of the decision-making process[1].

In parallel, the prescriptive nature of standards that are designed to make adjustments and oftentimes to submit individuals to specific standards - one of the dimensions of standardization applied to the health care processes - emphasized the quality assurance and safety of patients and professionals in service rendering.

According to Christensen[4], with the blooming of evidence-based health and of information technologies, standardization made it possible to transform problems, whose solution would require the contribution of high cost professionals, into interventions oriented by protocols and clinical guidelines. These management technologies have been reducing costs and enhancing the quality of health actions. In this sense, following the best practices to attain the best results, "*The transformational force* [able to bring] a*vailability and accessibility to other segments* [as well as for health] *is disruptive innovation* [including the management model]"[4].

As from the end of the 1990´s, the concept of clinical governance or clinical management brought new elements for discussion into health management, with a focus on the system´s responsibility to enhance the quality of healthcare. English-speaking authors use the term clinical governance more frequently[5] and explore the organization of the health system surrounding the articulation and the regulation of actions and services, all geared to effectiveness, efficiency and the development of national quality standards for health actions and services and for quality[6].

In Brazil, the use of the term clinical management is even more recent. The majority of articles and productions destined to the discussions of health systems, management models and health care do not use this descriptor, although they problematize these and other elements as co-management concepts and those of an expanded clinic. In these approaches, valuing the unique relationship built between the users and healthcare professionals, and the construction of action of these subjects in the process of reforming and reorganizing care has been put forth as a management model and as alternative care to the excessive valuing of management in healthcare[7].

Based on an initial conceptual approximation, what stands out as an assumption that should be studied is that health management and, more specifically, clinical practice management, has brought on tension produced in the dialogue between control-autonomy and standardization-singularity in health care. In this context, the challenge of increasing access and making available more qualified health actions and services remains current and continues to demand the production of innovation in care and management practices.

To be able to meet this demand, what is needed is a conceptual exploration of the expression clinical practice management. Problematizing this concept can spearhead not only the drafting of political guidelines relating to the health care model in Brazil, but also contribute to the development of strategies to be used in the daily routine of health care.

Based on this outlook, the present study begins with the following question: which meanings are given to clinical practice management, and which are the conceptual categories that involve such an expression?

Thus, considering the wealth regarding this topic, the objective is to explore the conceptualization of clinical practice management, with a view to gaining a better understanding of the diverse meanings that could be attributed to this expression.

This discussion can contribute to not only the planning and organization of health services geared to clinical practice management, but also to help set up principles to draft actions in this field.

Ciência & Saúde Coletiva, 20(8):2431-2439, 2015

Methods

This study should be characterized as a literature review, herein understood as being an exploratory study of the production of knowledge regarding a topic or issue. What was preferred are scientific articles as a source of analysis.

Initially, keywords on this topic were identified in the Virtual Health Library (VHL) corresponding to clinical practice management. With this phase concluded, search was centered on the database Medline. In this base, on October 25th, 2013 a search was carried out with the following strategy: '(clinical management) or "clinical management" [keyword of the subject] and (clinical governance) or "clinical governance" [keyword of the subject] and "Article in Journal" [Type of publication]'. Through this strategy, 224 titles of articles were found. Ensuing this, those titles that did not have abstracts in the base were excluded, leaving a remaining 164 articles.

As the studies that were empirical-qualitative or theoretical-conceptual were deemed to be more appropriate to respond to the survey question, the following inclusion criteria were used when reading the abstracts: articles with a qualitative method, theoretical essays, opinion articles or conceptual ones, and review articles in qualitative literature. On the other hand, the following exclusion criteria were used: article with an epidemiologic method, quantitative systematic reviews (meta-analyses) and quantitative articles in general.

By applying the inclusion and exclusion criteria in the reading of the abstracts, we identified 92 titles. When searching for articles, we decided to withdraw an article that had been published in the Czech language. Therefore, 91 full texts were read. During the reading phase, those studies which did not bring concepts, definitions or specific considerations on the issue were removed. Through this, the analytical body for revision ended up with 19 articles.

After reading the entire collection, each article was submitted to two analysis cards. The first– drafted with the objective of characterizing the production – and included the following variables: year of publication, country where the study was carried out, field of knowledge of the study, methodological design and type of source used. In terms of the methodological design, as we were dealing with qualitative or theoretical-conceptual studies, we adopted the following classification: empirical-qualitative, theoretical-conceptual, editorial/opinion and qualitative review. As regards the source, the classification was the following: primary, exclusively secondary and opinion.

In the second analytical card, conceptual parts or specific considerations were transcribed, regarding clinical management or clinical governance in the article.

The information recorded in the first card of each article initially underwent a descriptive treatment, with the use of frequencies. In the set of variables in this card, the priority was the type of source, as we deemed it important to identify if the concepts and the clinical management or clinical governance models were set up based on field surveys or from literature in general.

There was the analysis of specific concepts and considerations on the issue, recorded in the second card of each article, based on an adaptation of the technical analysis of the content, thematic modality, described by Bardin[8]. For this author, the theme is the unit of meaning that frees itself from the text analyzed and can be translated by an abstract, by a phrase or by a word. Through this technique, it is possible to identify what underlies the content manifested[9]. In this literature review, the topic is understood as being a broader category that can encompass more than one core of meaning. In synthesis, basically, these are the analytical paths tread: (a) identification of the core ideas of the parts transcribed from all of the articles; (b) classification of the underlying meaning for the ideas that summarize the production of knowledge regarding the topic studied and (c) drafting of the interpretative synthesis for each topic or theme.

Results

Characterization of the articles analyzed

When it comes to the year of publication, there is a predominance of articles published in 2010 (42%), followed by those published in 2012 (32%), 2009 (5%) and 2013 (5%). In this sense, we can consider that the production analyzed regarding the topic in general is relatively recent, encompassing approximately the period referring to the last five years.

Regarding the continent in which these articles were put together, those written in Europe are predominant (68%), followed by those from Oceania (21%), North America (5%) and Asia (5%). Since the largest number of studies comes from the United Kingdom, located in Europe,

and considering its influence in the oceanic continent, this could point to the predominance of the expression clinical governance, in detriment of the term clinical practice management or clinical management.

When it comes to the field of study, Nursing stands out with 27% of the group of articles, followed by Medicine (26%), Dentistry (26%), Public Health (16%) and Education (5%). The predominance of the first three areas may indicate that the discussion regarding this topic it at a micro level (clinical practices), and not at the meso level (organization and planning) and macro (policies). The scant involvement of the field of education may point to the need to go more in-depth in the discussion on professional training geared to clinical governance.

Regarding the types of sources used, in general the articles base themselves on those that are exclusively secondary, with 42%, followed by those that use the primary sources (32%) and those based on opinions (26%). The predominance of secondary sources may indicate that the concept of clinical governance is used based on other studies regarding this topic, with less investment being made in the construction of the concept beginning with empirical situations. Perhaps this can be attributed to the fact that the topic is relatively recent and the concrete experiences of the use of this concept are still in a stage of development and/or consolidation.

Issues in clinical governance

The authors of the articles analyzed used the expression *clinical governance* and, for this reason, the presentation of the results of this study and its discussion will center on this expression.

The concept of clinical governance in general is used in articles with other focuses of discussion that can range from considerations on interventions regarding specific health problems up to the planning and organization of health services. Commonly, the authors studied go through conceptual aspects set forth by other authors. Scally and Donaldson[5] are authors frequently cited in the articles. About 37% base themselves on these authors to define clinical governance.

The content analysis studies reviewed can be illustrated by a conceptual map, with areas relating to three concentric circles - in that, the central area refers to the concept studied; the intermediate one – divided into seven subareas – encompasses the thematic areas, and the external one brings together the meanings associated to the themes with the references of the authors of the studies analyzed. The analytical path began with the identification of the content in the external area, going through the classification of the intermediate area to indicate the clinical governance concept-synthesis that makes up the internal area.

Managing appears as a constituent theme of clinical governance. The authors also used the expression management, as both of these terms are used indistinctly.

Among those in which there was some mention, the following core meanings were found: people management, process management and management with actions aimed at corrections. Among the authors that point to people management, the term professional performance comes up[10,11]. Those who point to the aim as process management focus on benchmarking[12,13]. Another core of meaning is the connotation of management with action, therefore: implementation of the prescription[14] and intervention[10,15]. In this core, the authors use terms with connotations of action to resolve poor performance, bad performance and precariousness.

The purpose of management as an element of clinical governance for these authors is geared to the action of transforming and to the attainment of results (efficacy) by correcting insufficient professional performance. Additionally, it is signaled out that clinical governance is a set of practices that should be applied in all health systems.

Although the enhancement of quality does appear in the group of themes – implicitly or explicitly –a specific theme can be identified that refers to the *promotion of quality*. The central focus of this theme is composed of two meanings that point to results that will reveal the quality of clinical practices.

In terms of strategies to attain quality in clinical practice, there are studies that have focused on the development of protocols[13,14]. One of these studies highlights the implementation of protocols to orient the prescription by non-medical professionals[14]. Regarding the studies which focus on the promotion of quality in results, those that stand out are focused on the quality of clinical practice per se[15-17], the enhancement of the quality of care[18], efficacious services[19] and the efficacy of care[13,19-23].

Monitoring or clinical auditing also emerges from the texts as a theme. Authors use this expression as one of the clinical governance components. In one study, auditing is considered a s a being a key point for clinical governance[24], while

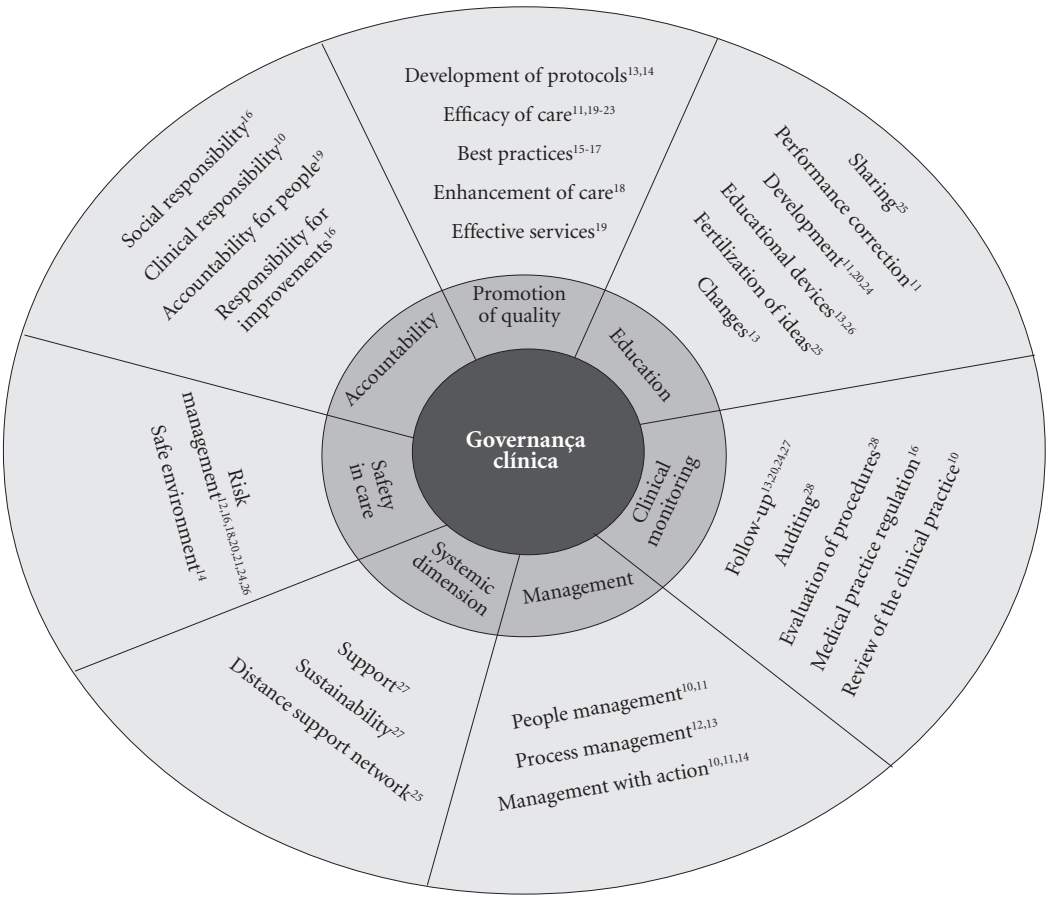

Figure 1. Conceptual Map.

others mention this term as follow-up, without defining it[13,20]. Among the authors that explain the meaning of this expression, there are the following cores of meaning: systematic approach to review the clinical practice[10]; regular evaluation of operational procedures[28] and regulation of medical practice[16].

Using terms such as monitoring, auditing or clinical supervision, this theme is presented with a focus on services and teams[13] and in the activities of clinical medical professionals[26], dentists[13] and nurses[27]. The purposes of auditing are geared to enhancing performance, based on an awareness of the extension of the nature of the mistake or error, as well as the need to improve standards for practice and work processes. By approaching this purpose, the sense is to foster changes in the practice of professionals, auditing is tangential to the theme education.

Education as a theme is another component of clinical governance. For one of the authors, it is deemed a crucial and close link, core to clinical governance[11]. Still following this meaning, it is signaled as leveraging the quality enhancement and the correction of bad performance[11]. As cores of meaning, what can be highlighted is the sharing of practices[15]; a change in practices and the behavior of professionals[13]; cross- fertilization of ideas[25]; continuous professional development[11]. Some authors signal to this component without qualifying it[20,24]. Others explain tools or devices that can be used for learning and for professional development, such as: telecommunications[26], critical incident[13] and survey-action[13].

Responsibility or accountability has been mentioned as another theme that emerges from the texts. That expression used has the following meanings: being responsible in the exercise of clinical practice[10], being accountable for the people that will be cared for and serviced[19], enhancing the social responsibility of clinical governance[16] and further yet, the responsibility of the organization in the continuous improvement of quality of its services[12]. This is achieved through setting forth and guaranteeing high standards that create an environment that will stimulate excellence of care[12]. This being the case, responsibility refers to the individual, and to the service or center itself ("being responsible or accountable and being committed") to the target population of that activity. This accountability begins with a definition of the mission and the vision, and extends to the rendering of excellent services. The focus of responsibility would be, herein, the user of the services, besides the professionals[17].

The theme *safety in care* holds two meanings: risk management[12,16,18,20,21,24-26] as well as a safe environment[14]. Concern with safety arises when there is the observation of the magnitude and the nature of errors relating to medical practice, and the need to improve standards that refer to the health practice and planning[12,16,25]. The patient´s safety will help professionals manage risk, thus reducing the "threats" associated to care[24]. On the other hand, risk management is deemed to be one of the pillars of clinical governance[21]. When it comes to the second meaning, there is one study[14] that considers the organizational perspective to ensure a safe environment for professionals.

Finally, what stands out is the *systemic dimension* as a theme of clinical governance. Three cores of meaning are part of this theme: support[27], sustainability[27] and a distance support network[25]. In the first two meanings, the systemic dimension takes place when we advocate for clinical supervision to support nursing professionals, allowing for sustainability in the clinical practice[28]. The third meaning, on the other hand, arises from the experience of a program that structures clinical governance in such a way that it can maintain the services in remote sites through a distance support network[25].

Discussion of results

The meanings attributed to clinical governance present in the articles analyzed are not far from the concept regarding the theme systematized by Scally and Donaldson[5]. According to these authors, clinical governance is associated to the continuous promotion of quality enhancement, guaranteeing high standards of care and creating an environment geared to clinical excellence. For them, the promotion of quality in clinical governance relates to the concept of clinical quality set forth by the World Health Organization (WHO)[29], that translates into four aspects: technical quality of professional performance; efficiency in the use of resources; risk management and patient satisfaction with the services rendered. Beyond these aspects, what stands out is accountability in the organization of health systems, in guaranteeing high standards of clinical attention. In this sense, the positive results for the patient orient towards a systemic dimension and an organization of health services in an integrated network of services and professionals.

The conceptual elements of the authors mentioned herein and the WHO aspects referring to what clinical quality truly is are structuring in the conceptual chart that arises from the analytical body of this study. This is observed even in those articles that do not mention Scally and Donaldson[5], nor the WHO[29], to structure their definitions on this issue.

The themes in the conceptual graph presented are part of a core of meanings that relate to practically the dimensions of the seminal discussion of the authors mentioned[5]. In the group of articles, only the patient satisfaction with services rendered has not focused explicitly on the concept of clinical governance. Despite this, the notion of accountability presented relates closely to users.

The definition itself of governance reinforces this vision (a set of activities that guarantee the adequate functioning of services, making it possible to honor the commitment taken on regarding the target population)[19]. Patients´ satisfaction would enter here as a finding of how this commitment has been adequately complied with and made concrete (or not).

In the articles analyzed, the meanings attributed to clinical governance in general relate to the operational actions and procedures that bring closer the management logic to the logic of the clinical practice. Albeit having a focus on operational instances, the devices approached have in view a quality enhancement. This dimension, based on Campos and Amaral[7], can be associated to a management model called technical-operational, linked to a more technocratic and managerial line.

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Among these operational devices, auditing in clinical governance was presented in a way oriented to improving the action of professionals, teams and services, particularly those organized in an integrated way. Notwithstanding the coherence of purposes in the use of this tool, it was not possible to fully identify the relationship between the degree of autonomy and control in the realm of auditing.

In the group of articles reviewed, there is an emphasis on the mechanisms for detection of non-conformities in professional behaviors, and for the control and standardization of professional work. In a certain way, that reinforces the predominance in health of control through disciplinary and normative processes, in detriment of scant or no investment whatsoever in changing values and professional stances[7].

For Cecílio[30], the category "power" should be used to analyze relations and management models, in the sense of verifying the possibility of the existing negotiations among the multiple rationalities, interests, disputes and knowledge. This category, applied to the analysis of auditing processes could prove in which degree the control was used to annul professional autonomy, and in which measure the protocols or clinical guidelines are references that allow for contextualization and singularity or not.

Still regarding devices, one of the articles approached protocols as a tool to support the prescription of non-physicians, guaranteeing quality at a lower cost. It is worthwhile emphasizing that, whenever studies reviewed mentioned costs – implicit or explicitly – they did so in a way that is coherent with the Christensen et al.[4] premises. Therefore, cost reduction matched an increase in quality in health actions, particularly with clinical protocols.

In the theme education, the explanation of approaches used was different in the work studied. While some of the authors indicated educational processes geared to building a support network among professionals, with cross fertilization of ideas[25] and shared practices[15], others did not qualify the training processes[20,24] nor the research ones and the correction of behaviors[10,15,16,28].

The degree in which training or reported performance correction considered the characteristics and specificities of each context and case, and the outlook of diverse actors involved was not pointed out. This indication would be essential to allow for a more in-depth analysis on the role of education in clinical governance, considering the use of the directive or constructivist forms of education. Screening forms and the organization of educational content or the choice of teaching techniques and evaluation reflect the understanding of how people learn and if knowledge is used to free or to dominate the other[31-33]. For Becker[34], a constructivist educational approach bases itself on valuing and making a reflection of the other´s experience, as a springboard for the production of new knowledge. In the opposite direction, the directive educational approach is oriented to transmitting knowledge, with a view to repeating the content transmitted.

Underlying all of the meanings attributed to governance, what can be observed is the predominance of the biological dimension that institutes a specific mode of practicing clinic and leans towards the creation of protocols and clinical guidelines, founded on this perspective. In this fashion, although they are constituents of the health-disease process, social dimensions, including biopolitics[3] and the subjective one[7] are not mentioned in the articles studied.

Perhaps the option for the biological has its roots in the origins of clinical governance; that is, as a response to the lack of safety and quality of care evidenced through the scandals that rocked the public´s trust in the health system, an example of what took place in the United Kingdom. Furthermore, there was the need to offer a rapid response to the questioning that such events gave rise to[18]. Nowadays, years later, the limitations of this option clearly faced the need to value subjects and other dimensions that are part of the health-disease process, beyond the biological perspective.

Final Considerations

The meanings attributed to clinical governance compose a picture of polisemy that relates more to the pole of expression of the term than to the logic commonly present in this concept. In other words, in general, the variation of meanings relate to the way in which the authors of the studies reviewed express or unfold the structuring conceptual components broadly accepted as clinical governance.

Although in isolation the articles do not provide a deeper technical conceptual movement specifically geared to clinical governance, as a group of articles- as an analytic body – they offer subsidies to discuss the topic. Although there are commonalities or intersections between the

ideas present in the concepts of the articles, the approaches are different.

In this body of analysis, we observe the tensions between control-autonomy and standardization-singularity in health care. It is of fundamental importance to dialectically confront the first components of tension (control and standardization) with the second (autonomy and singularities), allowing for a reflection on what, how and what for of changes in clinical governance.

Based on the concepts studied, there are gaps in knowledge when it comes to the topic researched. Although some authors have approached the issues or organization and planning relating to clinical governance, the discussion predominance is upon the operational instances. There has been no major investment in studies at the meso and macro spheres relating to this topic. In other words, what is missing is a focus on discussions on planning and policies relating to clinical governance.

In conceptual terms, further reflections are needs regarding the use of the expressions *management and governance*. Would these uses reveal the synonyms, different translations between languages or perspectives regarding clinics?

Finally, there is a limitation in the present study. Due to the methodological choice of working with the keywords integrated in the VHL, and as previously the option to analyze qualitative approaches, studies that are important to go more in depth into this matter may not have been reviewed. This is one of the reasons for the fact that national publications on clinical management – used as a starting point for this study – did not appear in the search.

Aware of the limitations, this study should be understood as a starting point or a trigger for future analysis on the two axis of discussion regarding clinical governance: relation between the spheres (policies, planning and operationalizing) and a greater investment in autonomy and singularities.

Collaborations

R Gomes and VV Lima were responsible for structuring the article, analyzing the sources and drafting the article. JM Oliveira, LMC Shiesari, E Soeiro, LF Damázio, HL Petta, MS Oliveira, SF Silva, and SF Sampaio participated in the analysis of the sources and in drafting the article; RQ Padilha, JLM Machado and G Caleman were responsible for the search and analysis of the sources.

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Article submitted 04/06/2014
Approved 03/09/2014
Final version submitted 05/09/2014