RESEARCH ARTICLE

Clinical Governance: The Challenges of Implementation in Iran

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Abstract

Background and Objectives: The Iranian Ministry of Health and Medical Education has introduced clinical governance as the accepted model of hospital healthcare improvement. Subsequently, a growing movement for implementing clinical governance in health facilities has emerged. This study aimed to explore the opinions of the relevant experts and executives to provide insight into current challenges, barriers and inadequacies in implementation of clinical governance in Iranian health settings.

Methods: A qualitative approach was adopted. A purposeful sample of 17 participants was interviewed in the spring of 2012. The study sample was selected from among clinical governance executives of teaching hospitals affiliated with Kerman University of Medical Sciences and the academicians involved in administration of the clinical governance. The Framework method was adopted for data analysis.

Findings: Seven themes explain challenges of implementing clinical governance, including human resources, management, communication, training, culture, resources, and monitoring and regulations.
Adequate quality human resources, particularly experts in clinical governance should be dedicated.
Leadership commitment to support implementation of clinical governance should be improved. Administrators need to get more familiarized with the concept and requirements of clinical governance. High ranking authorities should avoid rapid turnover of management teams.
Adequate communication regarding of clinical governance is needed to be established among different deputies of the Ministry of Health and Medical Education. Hospitals must be encouraged to share their experiences in clinical governance.
Training programs should be based on needs assessment, have definite goals, and focus more on practical aspects of clinical governance.
The felt need for change must be promoted among hospitals' administrations and staff. Teamwork between staff must be promoted. Expectation for rapid achievements and early frustration in time taking reforms must be addressed by appropriate training.
Appropriate infrastructure and mechanisms for reporting, interpretation, and analysis of quality indicator data should be developed. Adequate financial and physical resources should be appropriated.
Efficient monitoring and assessment systems must be implemented. Progress in implementation of clinical governance should be appropriately supervised and evaluated. Constant feedback on staff performance and outcomes of interventions should be provided.
Adequate supportive laws and regulations, legally guaranteeing implementation of clinical governance should be developed.

Conclusions: Considering inter-relation of the identified themes and subthemes, our study recommends that a systems approach should be adopted for successful implementation of clinical governance. While fundamental solutions to the identified challenges require long-term reforms in the health system, some obstacles such as inadequate leadership support, rapid rotation of managers, lack of financial and physical resources, inefficient monitoring system, and inefficient training programs may be addressed in a relatively short run.

Keywords: Clinical Governance, Quality Improvement, Hospital, Health Care

Background and Objectives

Today, there is an increasing pressure on health systems for higher efficiency and improved performance [1]. An ever growing number of countries are adopting hospital performance improvement as a major policy towards improvement of their healthcare system [2]. Among various approaches to improvement of hospital performance is the Clinical Governance (CG) that has received significant attention in the past decade.

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CG was first introduced in 1997 in the UK health system as a government strategy to improve the quality of clinical care [3,4]. CG is described as a systematic and integrated approach that supports any action towards maximized quality of healthcare services [5]. This approach provides a comprehensive and powerful mechanism to ensure high standards in clinical care and at the same time facilitate continuous improvement of these standards [6,7]. The successful implementation of CG in the countries adopted it as the dominant healthcare system improvement policy, promise similar results in other countries [8].

The Iranian Ministry of Health and Medical Education (MOHME) emphasizes achieving quality hospital care as a major goal of the national health system [8, 9]. Considering the strengths and weaknesses of different approaches, MOHME was convinced to introduce CG as an accepted model of hospital performance improvement [Iranian health minister's official letter No.388044, November 2009 (Persian)]. In addition, the Iranian National Plan for Healthcare System Strategic Reform – which determines critical orientations of Iranian health care system until 2025 AD – particularly emphasizes the importance of CG promotion. [10]. Built on these upstream policies, MOHME has obligated all hospitals to develop the necessary infrastructures for CG implementation. Upon this obligation, a growing movement for development of CG in health facilities has emerged. However, progress in this field has not been straightforward [11]. CG implementation is a complex, multi-faceted and dynamic process and identifying suitable procedures for its development requires a thorough understanding of the current state of the target health system [12, 13]. It is also notable that the CG framework has been developed based on the history, context and specific requirements of UK's National Health System [7]. While quality improvement plans in a specific country can benefit from international achievements, their success is contingent on their relevance to the local challenges. Several years after hospitals' preliminary movement toward CG, now it is time to evaluate the challenges, barriers and inadequacies in the path of its implementation. Identifying the context and practical challenges in quality improvement has a profound impact on effective planning, implementation, and modification of initiatives [14]. This study explored the opinions of experts and executives as a contribution to addressing such a need in the field of clinical governance.

In practice, implementation of clinical governance is realized by a set of coordinated quality improvement projects [15], thereby CG development shares many challenges with other quality improvement plans. One of these challenges is the uneven distribution of health care workers [16]. Despite acceptable growth of the quantity of healthcare professionals in Iran during recent decades, a balanced distribution of healthcare workers across the country has not been achieved [17]. Another obstacle toward enhanced healthcare quality is inadequate training programs. While the impact of training of administrators and employees on hospital services quality is well established [18], an overwhelming majority of managers and healthcare workers have not received required education to successfully adapt to new conditions [19]. Hospitals in developing countries are generally facing challenges such as inappropriate management of resources, low performance, unprofessional services delivery, inflexible organizational hierarchy, and lack of performance-based payment, all of which serving as barriers to quality improvement. In the present study, we investigated the barriers to CG-based health services quality improvement. Using a qualitative study design, we classified the opinions of several CG experts and administrative staff within conceptual themes. The results are interpreted in connection to the previously identified problems in the Iranian healthcare system, and implication of the results for CG development is discussed. The findings may also be partially extendable to the health systems of other developing countries.

Methods

Study Design and Settings

This study is a qualitative study conducted in the spring of 2012. The study was carried out at Kerman University of Medical Sciences (KUMS), situated in Kerman, the largest province of Iran. KUMS has been classified among the top eight Iranian universities of medical sciences. The university is in charge of monitoring the quality of services in hospitals of Kerman Province.

Participants

Using a purposive sampling method (Snowball method) [20], the study sample was selected from among CG executives staff of KUMS teaching hospitals and the academicians involved in administration of the CG plan. Participants were invited to an interview via email and cell phone and were presented regarding the purpose of the study. Sampling was continued to the point of data saturation. After 17 interviews, data reached saturation level.

Interview

Face-to-face interviews were conducted, recorded us-

Table 1   Thematic Framework: Themes and Subthemes Conceptualizing Barriers to Implementation of Clinical Governance

Them I: Human Resources

Shortage of experts familiar with clinical governance implementing strategies

Poor incentives among personnel

Shortage of manpower

Them II: Managerial Issues

Low management commitment

Unfamiliarity with managerial concepts

Frequent turnover of the managers

Inappropriate manager appointment

Them III: Communication

Lack of interactions among deputies of the Ministry

Poor intersectoral communications

Them IV: Education

Poor educational programming

High educational expenses

Them V: Cultural Issues

Lack of felt need to change

Hastiness in gaining results

Little attention to cultural conditions

Poor teamwork

Theme VI: Financial, data, and instrumental resources

Financial limitations

Poor access to data

Physical limitations

Theme VII: Regulations

Lack of patronizing laws

Poor assessment by the Ministry and the universities

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ing a digital recorder, and were then transcribed. The interviews lasted between 55-80 minutes. One of the authors (MJZ) carried out all the interviews. The semi-structured interview questions were designed so that they solicit the opinions of the participants with regard to clinical governance.

Data Analysis

The framework method was adopted to analyze transcripts'contents. The framework analysis comprises five steps, including familiarization, identifying the thematic framework, indexing, charting and mapping and interpretation [21]. This method is specifically developed for the analysis of qualitative data in policy-related research [20]. A form summarizing the content of each interview was developed during the familiarization step. The structure of the form was gradually developed based on the content of previous interviews. A primary thematic framework was developed based un literature and then discussed during targeted iterative meetings among the research team.

The framework was examined against the interviews by repeating the familiarization process [22]. One of the authors (MJZ) indexed the transcripts with codes associated with the thematic framework [21].

Wherever appropriate, the sections of data were

coded with one or more codes (cross-indexing) [23]. Other researchers discussed the coded text, and adjustments were made where necessary. This process was repeated several times for each interview.

For each theme, a table was specified with rows related to interviewees and columns related to sub-themes. The data were transferred into the table to create analysis 'charts'. By browsing across the rows, opinions of each interviewee concerning different themes were compared. Similarly, by browsing across the columns, opinions of different interviewees concerning a specific theme were compared. We also investigated the relationship between themes and subthemes. Results were interpreted in an iterative fashion similar to the indexing process. The thematic framework was frequently updated during the analysis process [21].

Ethical Considerations

The approval of the Ethical Committee of KUMS was obtained before conducting the study. Verbal consents were obtained from the participants before the interview.

Results and Discussion

Seven themes and 20 subthemes abstracting the major barriers to CG implementation were identified (Table 1).

Theme I — Human Resources

It is well established that human resources (HR) are the most important asset of any organization [24]. Indeed, success of an organization is an ultimate result of the efforts made by its employee. In our inquiry, shortage of human resources was identified as one of the barriers to implementation of CG. "*When talking about the necessity of certain activities, one should ask whether the available workforce adequately meets the volume of the work required*" (M4). In addition, shortage of experts familiar with the requirements of CG was identified as an additional HR challenge to develop CG. "*They [authorities] tell us that you can have four CG experts. While contribution to CG development is usually the secondary activity of these people, they do not have sufficient expertise in the field*" (M2). Further, lack of incentives was emphasized as a barrier impedine active participation of hospital staff in the CG promotion. One of the interviewees stated that "*Motivational incentives are not adequate..Suppose that the personnel were traine; what will then be their motivation to contribute to the plan? Is there any incentive supported within laws and regulations? … There are only a limited number of self-motivated people who are ready for cooperation. Hence, suitable incentives should be de-*

vised for this purpose" (M1).

According to the interviewees, physicians were among groups least interested in CG promotion. "*Most physicians are still not familiar with the concept of clinical governance although years have passed since its inception*"(M15). Moreover, due to incomplete implementation of some previous quality improvement initiatives and lack of tangible outcomes, acceptance of CG as a new quality improvement plan faces a "*critical challenge*": "*Personnel are weary of hearing about [unfruitful] quality improvement plans*" (M6).

Theme II — Management

Senior managers' inaction was another identified barrier to implementing CG. Studies identify lack of leadership commitment as an important barrier to successful implementation of quality improvement plans [25]. According to interviewees, insufficient senior leadership commitment has resulted in lack of some needed supports: "*True commitment is expected to render comprehensive support of the CG implementation by senior leaders, something not being the case in practice*" (M3). In a similar study, Rashidian outlined the difficulties of CG implementation, and emphasized that the efficiency of the plan is largely dependent on the degree of support from hospital managers [25]. The leaders' sectional and command-oriented attitude toward a fundamental projects, and leadership's failure to pursue plans in the long term, leads to a fact that "*a command is voiced from higher rank authorities, then managers mobilize staff to run it, …, but after a while the sensitivity disappears*" (M9). In addition to having adequate knowledge and experience, competent managers need to constantly update their knowledge in response to the emerging challenges. Lack of up-to-date knowledge and technique, and employing outdated managerial approaches was described as a barrier to CG promotion. "*Some people with administrative or decision-making positions still cannot think out of box*" (M10). Recruiting of individuals with no limited specialty (e.g. physicians) for administrative positions was criticized by interviewees. In response to a question on potential solutions to CG development, a participant responded, *"Employing graduates of managerial disciplines can be really helpful"* (M1). Referring to the coordinating role of administrators, he added "*[Graduates of management disciplines] can transfer their expertise to all levels of the organization, but a physician-dominatet system does not allow such an advantage*" (M13). individual decision-making rapid turnover of senior managers, and inattention of a new managerial teams to the programs pursued by former managers were mentioned to result in failure of the plans and waste of resources. "*Employees are faced with the ques-*

tion that if Dr. X and their team, who are now in charge in the Ministry [of Health], leave[their job] tomorrow, what will then be the faith of the [CG] plan?" (M1)

Theme III—Communication

It was found that inadequate communication between different levels of health system impedes the development of clinical governance. "*Appropriation of funds by the Budget Office of the Ministry [of Health] should be based on hospitals' performance in CG development. To this end, different deputies of the Ministry should have sufficient inter-communication. At present, there are many problems in this regard*" (M1). In addition, "*knowledge exchange among hospitals*" was described as *"insufficient"*. "*Inadequate communication between hospitals*" "*impede hospitals learning from each other*" (M3) in terms of CG development. It also appears that award-based motivation of hospitals for quality improvement negatively affects knowledge exchange between hospitals. One of the interviewees stated that *"…award-based motivation of hospitals [for quality improvement] leads to stringent behavior by hospitals in exchanging their experiences. This year I observed that as the [Hospital Quality] Festival approached, hospitals limited their visit permissions, and in the few visits that were done, they exchanged limited crucial information to prevent disclosure of their innovatione*" (M1). Similar studies have also identified intersectoral communication problems in the Iranian healthcare system [26].

Theme IV—Training

Lack of appropriate education and the related challenges servs as a barrier to CG development. Among the most important points in this area, inappropriateness of educational planning can be identified, which renders the training programs irrelevant to the actual needs. "*The trainings are not based on needs assessment. What are the quality problems in our services? What inadequacies in knowledge and skill have led to these problems? The training and skills development programs should be based on these inquiries*" (M5). In addition, failure to set learning goals before planning a training course results in ineffective training programs: "*During the training courses we do not know what we should learn. There are some training tours, but they are not sufficiently effective… Learning from successful hospital, needs some prerequisites. At the outset, we should set a goa]. We should know what, from whom, and how we are going to learn?*" (M12). As the training courses are not based on practical exercises, the participants remain unaware of "*how to*" and "*from where*

to*" begin implementation of the learned materials. In addition, lack of sufficient financial resources for planning high quality training programs was pointed out as another concern: "*To invite experienced mentors, you need to invest considerable funds. Such funds should be appropriated from hospital income, while hospitals already have serious financial problems*" (M6).

Theme V — Cultural Issues

In developing countries, cultural factors are among the most profound challenges in improving quality of healthcare services [27]. Previous studies reported an unsatisfactory level of organizational culture indicators in Iranian hospitals [28]. Although cultural issues are of diverse dimensions by nature, interviewees emphasized a number of particular aspects. One stressed subthemes was the widespread lack of desire for change: "*For every change to occur, two particular questions should be answered: why to change' and how to change?' We have a great problem concerning the first question… In [most] hospitals no need is felt for change*" (M3). Furthermore, insufficient understanding of the nature of quality improvement, and expectation for rapid achievement leads to early disappointment in the effectiveness of interventional programs. One of the interviewees said: "*After a few months, all people would say that the [clinical governance] plan did not work out either*" (M1). Successful performing of quality improvement procedures, Successful performing existence of cultural infrastructures [29]. Healthcare organizations need to help staff acquire deeper insight into the complexities of quality improvement plans by appropriate training.

Our results imply that the barrier to creatg such a culture is related to the instability of management team on the one hand, and their insistence to achieve the results within the period of their administration, on the other hand. To alleviate this problem, administrators need to be trained in terms of cognitive and change management skills.

Successful implementation of quality improvement programs entails avoiding blind adoption of models administered in other countries and giving close attention to national cultural characteristics. Following previous models, without necessary adjustments to the elements of native culture can lead to unexpected problems. In this regard, an interviewee mentioned one of his experiences: "*One of our nurses introduced herself to a patient, and in the following week, the patient proposed marriage to her with a bunch of flowers*" (M16).

The interviewees also mentioned the weakness of

teamwork culture among the barriers to CG development. "*We seldom consult each other in solvine a problem…Different working groups either do not understand each other, or view consultation as a weakness*" (M15).

Theme VI — Resources

Campbell identifies resources limitation as one of the barriers to improving quality of services [4]. Problems such as problematic insurance reimbursement, surreptitious tariffs and indefinite financial resources, impede successful implementation of CG plan. "*Patient safety will be practically questioned if we do not have suitable beds and proper bedsides*" (M2). Yet, scarcity of financial resources is another concern of the interviewees. "*The financial resources of this plan are not clearly determined at both Ministry and university levels*" (M1). "*Late insurance reimbursement is one of the fundamental weaknesses of financial leverage… that persuades many individuals to work in private hospitals rather than in public hospitals because of their timely refund*" (M9).

In addition, lack of necessary mechanisms for information collection was identified as as a further challenge. "*Clinical governance establishment has some indicators that need to be evaluated following interventions. However, the statistics of such indicators are not adequately available*" (M10). Studies show that developing countries have major problems in the implementation of health data systems [30-32]. Success in all stages of quality improvemens, including planning, administration, and evaluation is contingent on the availability of information about current state of the target variables. Development of an effective CG strategy is not an exception to this rule. Therefore, in order to succeed in CG timplementation, appropriate mechanisms for reporting, interpretation, and analysis of information should be developed [33].

Respondents also pointed out limited physical resources as a challenge to quality improvement: "*Our emergency rooms are not spacious enough, nor are they built in compliance with the standards. An immediate consequence of these insufficiencies is that patient privacy and quality of services will be compromised*" (M13).

Theme VII — Supervision and Regulation

CG implementation requires supportive laws that according to the interviewees, whose legislation is at least partially neglected. Previous studies have reported a lack of necessary laws to protect developmental plans in the Ira-

nian health system as well [34]. According to an interviewee, "w*e need a comprehensive set of supporting laws for successful implementation of clinical governance, which is unfortunately lacking at present*" (M1).

Respondents expressed dissatisfaction with the current approach to evaluating CG progress and provision of feedback by the MOHME and the universities in charge of monitoring the plan. "*We don't have strict supervision on this issue. Supervision of the universities by the Ministry, and supervision of hospitals by the universities is insufficient*" (8). "*There is no evaluating team from the university to notify us of our weaknesses and strengths. Waiting for infrequent visits by the Ministry to receive feedback about our performance does not comply with the requirements of this plan*" (M2). "*We lack serious and continuous monitoring. Universities have no authority to supervise non-university hospitals. There is no close relationship [between different health provider organizations]. For instance, [we should ask] how private hospitals are supposed to be involved? Whether their involvement is obligatory or voluntarily? How responsible they are for implementation of the [CG] plan?*" (M1). Inadequate monitoring of the CG plan appears to have led to the perception that involvement of health institutions in the CG promotion "*is voluntarily at present*" (M8).

Summary and Implications for Policy

The present study attempted to provide insight into the most important challenges toward establishing clinical governance in the Iranian hospitals. Seven themes including human resources, performance of senior managers, communication, training, cultural issues, resources, and finally laws and regulations were identified to conceptualize these challenges.

These themes, while pointing to specific barriers to CG development, are at the same time interrelated. For instance, one can pursue the roots of inefficient management and low performance of training in cultural weaknesse. Cultural underdevelopment, in turn, can negatively influence the communication and cooperation of hospital department. Therefore, our findings strongly recommend that for the successful implementation of clinical governance, adoption of systems approach is required. Adoption of the systems approach implies accounting for all contributing factor, and their interactions as well as the dynamic nature of CG implementation. Whereas it seems that high-ranking Iranian health authorities are committed to pursue a holistic and systems approach in the CG implementatione [11], there is little evidence to show

that such a perspective is institutionalized in the body of the healthcare sector.

The general yet growing shortage of qualified healthcare workforce – which is frequently reported as a healthcare improvement barrier in developing countries [35] is also reflected in our study. While fundamental solution to this challenge requires long-term reforms in the healthcare system, some relevant problems such as lack of employee motivation, sense of early frustration due to failure of previous initiatives, and shortage of CG experts, can be addressed in a relatively short run. It is notable that although the aim by CG is to ensure high standards of medical care for patients, indeed the healthcare professionals are in frontline for realizing this goal. Hence, deficiencies such as shortage of CG experts and low employee motivation require immediate attention.

Our study revealed the major managerial challenges involved in establishing clinical governance. Many studies have identified leadership commitment and management involvement among the critical requirements of CG implementation [26, 28]. Studies also emphasized the need for recruiting administrators with high cognitive and change management skills in order to introduce in-depth reform in the organization [4]. Insufficient administrators' commitment, their limited managerial skills, and instability of managerial strategies due to a rapid rotation administrators, send out alarming signals regarding the successful promotion of CG in Iran. These findings strongly emphasize the need for revising the current approach to appointing managers and use of experienced and competent administrators in order to successfully implement clinical governance. In connection to the training issue, respondents' view recommend that training programs should be based on needs and purposes. Employees should know what they are expected to learn, why they need it, and how their learning can help them improve their abilities in performing their CG-related tasks. In addition, training programs need to focus more on practical aspects of CG and make clear how to implement the acquired knowledge.

Our study revealed crucial cultural barriers in the path towards CG implementation. The most fundamental cultural problem turned out to be the lack of felt need for change at different organizational levels. Numerous studies have indicated positive relationship between leadership behavior and organizational culture in the hospital [26, 28, 36]. Therefore, one of the major prerequisites to overcome lack of desire for change is that the leaders themselves belief in the need for change, and acting accordingly. In addition, as mentioned above, managers must have the ability to make effective changes in a way that their outcome are tangible to staff. The implementation of these pre-requisites is crucial in deepening sense of need for change and continuous improvement in the organizational culture. Thereby, the organization would gradually gain the capacity and agility for flexible adaptation to the emerging needs.

Among other cultural subthemes was employees' rush for achieving results, and their frustration if the goals were not achieved in the short run. The problem can be partially attributed to the cultural contexts of developing countries. However, a deeper problem perceived from the interviewees' statements is that the expectation for rapid achievements is also prevalent among managers. If leaders expect immediate results from the implementation of the CG plan, this would imply that leaders themselves are not adequately familiar with the concepts and requirements of clinical governance. This observation is supported by statements of the interviewees in this study who, pointed out the limited familiarity of administrators with management concepts. Therefore, our study highly emphasizes necessity of recruitment of qualified administrators as a determinant of successful CG implementation.

Promoting a rich organizational culture and encouraging employee involvement, are essential to improving functions and processes in hospitals [28]. According to Ronald *et al.* development of a blameless culture is a prerequisite to successful implementation of CG [33].

An important finding of this study was the inconsistency between current score-based motivation strategies and the hospitals' tendency to share experiences. Unwillingness of private hospitals in disclosing their success secrets is explicable regarding the competitive nature of the market. In addition, private hospitals, considering their relative financial strengths, can more readily access the knowledge and techniques for quality improvement. However, in the public sector with limited financial resources, the above-mentioned inconsistency reflects inefficiency of the policies. A modified strategy in this context can be partially described, for instance, by scoring hospitals also based on their tendency to share their experiences with other clinical institutions, as an indication of their commitment to overall health system improvement.

The present study also identified the weakness of the intervention assessment system as one of the obstacles in CG development. Without periodic monitoring of the quality indicators, it is not possible to provide feedback from the outcomes of interventions Hence, hospital managers should emphasize development of efficient monitoring and assessment systems in order

to successfully conduct CG implementation.

Expert interviewees in this study also highlighted lack of sufficient supportive laws for, legally guaranteeing implementation of clinical governance. For a strategy that is defined by "responsibility" of healthcare organizations to improve quality of servicds, it is required that a comprehensive set of supportive laws be available. It is notable that some developed countries that currently follow clinical governance as their healthcare quality improvement paradigm, have a long history of legislations for protecting improvement of health system quality. Clinical governance in these countries is now based on this legal infrastructure. Therefore, success in establishing clinical governance in Iranian health system it contingent on the development of legal mechanisms supporting requirements of healthcare quality improvement.

Study Limitations

Qualitative studies allow for in-depth analysis of factors influencing outcomes, and provide a basis for developing conceptual frameworks for assessment and pathology of the interventional programs. Nevertheless, this type of study does not compensate for the necessity of quantitative assessment of contributing factots. Statistical modeling and analysis, allows for quantitative identification of the causal relationship between contributing factors, ranking influencing factors, and determining policy priorities. Although the present study was carried out using a small samples and on a local scale, there is little reason to believe that the challenges identified in the establishment of clinical governance are not common with other hospitals in the country. Meanwhile, to improve the present approach to CG development, assessment of the current challenges at national level in required. Such assessments can identify other aspects of the CG development challenges that may not have beed captured by this study due to its limited scope. In addition, this study explored CG development challenges only in public teaching hospitals. A more comprehensive insight into the CG promotion barriers require inclusion of hospitals of different types into the survey plan. Such a survey can lead to differential interventional strategies for hospitals of different tyes, ownership, geographical status, and cultural and environmental conditions.

Conclusions

The purpose of this study was to provide insight into the challenges facing the promotion of clinical governance in the Iranian health system. The Framework analysis of experts' views led to the identification of seven key themes in establishing clinical governance, including human resources, managerial issues, communications, education, cultural issues, resources, and regulations. These themes and the related sub-themes reflect the contexts in which threats to the successful implementation of clinical governance can emerge and grow. Some major problems, including management instability, lack of leadership commitment, lack of desire for change, and managers hastiness in achieving results are severely in conflict with the basic requirements of clinical governance development, and calling for immediate attention. Identifying these factors can contribute to the improvement of the current CG promotion strategies and help developing guidelines to facilitate administrative processes of CG implementation.

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