From the Editor

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The 'sheer thrill of tackling problems of human disease'[1]

'Clinical research describes the study of applied physiology, clinical observation and patient experience'[2] by taking research from the laboratory back to the bedside[3]. Clinical research is now to be promoted by new clinician scientist posts, while College lectures, many of which are published in *Clinical Medicine*, describe important clinical advances by some of our very best clinical scientists. New visions for the treatment of stroke, asthma, pulmonary hypertension and the acute coronary syndrome, descriptions of new understandings of malaria and the magic of neurochemical brain imaging, have all been published in the journal during the last year. In this issue, Professor Christopher Mathias examines the many causes of failure to maintain the 'fundamental human expectation to stand upright' in another model piece of clinical research[4]. After examining the diversity of adaptations in nature by which sea snakes, land snakes, tree snakes and giraffes cope with gravitational stress, Professor Mathias describes the numerous disordered physiological, neurological, biochemical, immunological and genetic mechanisms which lead to orthostatic hypotension in man, and makes an attempt to map the relevant cerebral autonomic centres. His understanding of the rare biochemical deficiency of dopamine beta-hydroxylase, resulting in the absence of circulating catecholamines causing severe orthostatic hypotension, followed by its correction with the pro-drug L-threo-dihydroxyphenylserine (L-DOPS) transforms the lives of patients.

And there is more to come. In the next issue, Professor Patrick Maxwell, in his Goulstonian Lecture, will describe the ways in which gene expression can be altered by low oxygen levels acting through a cellular oxygen sensor, with considerable implications for understanding tumour growth, and potentially leading to therapeutic interventions whereby perfusion and survival of ischaemic tissues may be promoted. He goes on to show how defective gene products lead to the development of the hereditary cancer, von Hippel-Lindau disease.

Clinical research is indeed often thrilling and can flourish under the right conditions. It is extremely encouraging that there are now new developments in careers for clinical scientists, described in the editorial by Professor Charles Pusey in this issue[5].

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Clinical governance and risk management revisited

Even now many physicians scarcely understand the term 'clinical governance'. It means the corporate accountability for clinical performance[1] or, in the more lengthy definition of the NHS executive, the means by which organisations ensure the provision of quality clinical care by making individuals accountable for setting, maintaining and monitoring performance standards. Clinical governance is built into the structure of every trust, and will ensure the delivery of continuing professional development

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(CPD) and appraisal for consultants which will also form the central plank of revalidation. Now risk management is added to the duties of a trust.

In his College Bradshaw Lecture, Sir Liam Donaldson, the Chief Medical Officer, reminded physicians that erring is inevitable and suggested that harmful adverse events may occur in as many as 10% of inpatient episodes[2]. He established an expert group which published *An organisation with a memory: report of an expert group on learning from adverse events in the NHS*[3], subsequently reported as being 'strong on analysis of the problems although it inevitably falls short on solutions'[4] although the National Patient Safety Agency has since been established. The NHS has indeed lagged behind industry in learning from errors which may result from both human or organisational failures. As Sir Brian Jarman observed in his 1999 Harveian Oration, detection of faults by analysis of all the steps in risky processes 'may be more productive than finding fault with individuals'[5]. Examination of the roots of dysfunctional teams or individuals by RCP teams visiting trusts (at their request) represents an important initiative in this regard. Otherwise, inherent fear of 'naming and shaming' has held back the process of the reporting of adverse or near-miss incidents.

So what should be done? In this issue, we publish an article from the aviation industry[6]. It reports the experience of their Incident Reporting Programme over many years. Its success appears to be the result of confidential reporting (although anonymity is not and cannot be a feature), independence from management and freedom from external influences. There are some important messages and lessons for the NHS in their work.

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The pleasure of clinical practice: job satisfaction and the infrastructure

Most physicians enjoy the practice of clinical medicine with its human contacts in caring, teaching and research, and for the many challenges of diagnosis and treatment. Many also enjoy acute medicine, none less than Dr Bennett-Jones, as he showed in the last issue of *Clinical Medicine*[1]. His expression of this pleasure will sound a note for many:

> *I enjoy being on call for acute medicine…The extraordinary diversity of fellow beings each in various degrees of medical need provides endless fascination. The opportunity to explain diagnosis and treatment to the concerned, the bewildered, the frightened, the truculent and the frankly antagonistic is never boring.*

After the acute medical take has been completed, however, it is the defects in the infrastructure that let him down, and he explains why it is 'understandable that physicians such as myself express a preference for non-acute duties'. This is indeed a view clearly expressed in the third RCP consultant questionnaire recently circulated to every physician[2].

The failure of the infrastructure must be at the heart of much of the unhappiness of consultant physicians. It seems obvious that the proposed increase in the number of consultants will not necessarily improve job satisfaction unless there are significant improvements in the infrastructure as well. Many of the defects, such as shortage of hospital beds, lack of sufficient long-stay accommodation, and inadequacy of suitable information technology, will require the injection of substantial resources over several years and have been well described elsewhere. However, direct support for consultants by improving clerical and secretarial services could be provided much more quickly. The recent RCP report on skillmix[3] strongly advocated raising the status of medical secretaries, along with appropriate remuneration, and this measure alone, which could be rapidly implemented, could begin to improve the lives of many beleaguered consultants.

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