

Clinical leadership in the provision of hospital care

Must be improved to reduce basic errors in clinical care

Throughout the developed world, direct observation and reviews of patients' records reveal basic errors in the care of patients. A recent study from France showed that the oft quoted figure of 10% of adverse events arising from health care in hospitals is probably an underestimate.¹ How can clinical leaders help to solve these problems?

The first task for clinical leaders must be to make doctors and nurses aware of such errors and to teach them to understand the contributory factors. In the United Kingdom's NHS, all too often there is insufficient contribution to acute care from experienced and fully trained staff. This is exemplified by a study that showed a fourfold difference in mortality from major general surgical procedures undertaken in a British hospital compared with surgical mortality in a US counterpart,² and by another study that found that shortfalls in medical care contributed to 25 of 200 deaths occurring from illnesses requiring emergency medical admission to hospital.³

The fact that junior doctors are often stretched beyond their capabilities is underlined by the recent report of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), which examined the care of very ill medical patients before admission to intensive care. The ability of junior staff to seek advice and appreciate urgency, and the adequacy of their supervision by senior staff were rated as very poor in 20-30% of cases considered by the inquiry. Leadership and teamwork by consultants were also found wanting: more than half of them had no knowledge of, or input into, the admission of their patients to intensive care, and a quarter of admissions were made without the involvement of a consultant in intensive care medicine.⁴

Senior doctors might consider the effects of the loss of the traditional "firm" structure in the NHS—in which close knit teams of doctors, supervised by a consultant, worked closely with nurses and other clinical staff on designated wards. Today, medical specialists often provide assessment and care for acutely admitted patients in many scattered wards: this, coupled with the fact that junior doctors work in shifts, can make continuity of care extremely difficult.

Less obvious, perhaps, are the defects in communication between doctors and other clinical staff that have been so clearly described in observational studies.⁵ Attempts to foster collaboration can be undermined by differential power and status, lack of

interprofessional socialisation, and inadequate time devoted to team building. The problem is intensified by the pressure on nurses in charge on wards to enhance their managerial roles. Time spent on management too often leaves these senior nurses with too little time to provide the leadership required to maintain standards of clinical care.⁶ This can sap morale and may lead many nurses to seek career progression by becoming nurse specialists rather than ward sisters, a role that was once regarded as the apex of the nursing profession.

What qualities are needed for effective leadership? One persuasive argument is for managers to negotiate rather than impose new policies, and to recognise that their principal roles are to support professional staff while persuading them to acknowledge the need to increase their own accountability.⁷ Acquiring the skills needed for strong and effective clinical leadership is rarely seen as part of the clinical training and professional development of doctors. The NHS Leadership Centre provides courses for senior clinical directors,⁸ but clinical leadership is needed at all levels, not least in the clinical teams delivering day to day care in hospital wards. Traditionally, junior doctors absorb hierarchical leadership skills "by osmosis" from their chiefs, a model that is no longer appropriate for the effective working of multidisciplinary teams.

So what can be done? In England and Wales clinical leaders must look for improved ways of managing care for acutely ill patients, pending the universal introduction of intensive care outreach and the appointment of more doctors devoted to acute general medicine, as recommended by the National Confidential Enquiry into Patient Outcome and Death.⁴ In the United States the Institute of Medicine has identified the need for "transformational" leadership in health-care organisations that will transform the systems and processes that underlie quality of care.⁹

Much can be learnt from industry. An initiative by the Institute of Healthcare Improvement, backed by the Robert Wood Johnson Foundation, uses the car manufacturer Toyota as its benchmark for appropriate management and funds individual clinical organisations to seek means of improving the safety and quality of care. In such projects managers are involved directly with physicians, as participants and leaders. Together they seek to motivate workforces and provide technical expertise that enables more reliable care for patients.¹⁰ In the "Towards a Safer Culture" (TASC) programme

in Australia, skills for clinical leadership are taught in parallel with developing new clinical pathways for patients with specific conditions. This has led to significant improvements in the management of acute coronary syndrome and stroke.¹¹

Improving leadership skills among today's doctors is obviously important and necessary. We must also consider, however, how best to educate the next generation of doctors. A promising start has been made with the introduction of professional development programmes in the preclinical years, but few, if any, UK medical schools include leadership training.¹² Moreover, with the expansion of medical training and increasing numbers of students, there is the risk that clinical training will become less personal and bedside teaching will suffer. If we believe that medical education is a process of socialisation that needs to start early and continue throughout the training years, then this issue must be addressed.¹³

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Competing interests: None declared.

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Surgery versus intensive rehabilitation programmes for chronic low back pain

Spinal fusion surgery has only modest, if any, effects

The optimal management of patients with chronic low back pain remains a big challenge for today's healthcare services. In this week's *BMJ* Fairbank et al report how they assessed the effectiveness of surgical stabilisation of the spine compared to an intensive rehabilitation programme for patients who had had low back pain of at least a year and who were considered candidates for spinal fusion.¹ The authors found no clear evidence that primary spinal fusion surgery was more beneficial than intensive rehabilitation, supporting the idea that spinal fusion plays, at best, only a small role in managing chronic low back pain.

The relevant and informative randomised trial by Fairbank et al was pragmatic by design.¹ Patients with chronic low back pain were eligible for inclusion if neither they nor their doctors were certain about which treatment might be better. Patients in the surgery group were operated on by surgeons using a surgical technique of their choice. Patients allocated to the rehabilitation programme followed an intensive training programme for some 75 days, with individually tailored daily exercises, hydrotherapy, and cognitive behaviour therapy. Four additional follow-up sessions were scheduled during the next year and, in both groups, patients improved, although the surgery group scored better on just one of the primary outcome measures, the Oswestry disability index.

Clearly, the improvements over time were rather similar in both groups and, as the authors suggest, may well have occurred independently of the interventions. But the trial did not include an untreated control group. In addition, many patients in both arms of the trial still had considerable disability after two years.

Current clinical guidelines for managing chronic low back pain do not recommend spinal fusion, except for a very carefully selected and limited group of patients, so these do not have to be changed in the light of this new study.²⁻³ Spinal fusion seems to help some patients with chronic low back pain. However, we must find ways to identify these patients in advance using valid and reliable classification systems. Until then spinal fusion may, after all these years, still be regarded as an experimental treatment.

A Cochrane review on spinal fusion for degenerative lumbar spondylosis concluded five years ago that there was no adequate scientific evidence for the efficacy of spinal fusion surgery: most of the included trials compared different surgical techniques, but included no conservative treatment arm.⁴ Two subsequent trials for patients with chronic low back pain have reported conflicting results. Fritzell et al reported reductions in disability and pain two years after lumbar fusion, compared to non-surgical treatments.⁵ This study was criticised, however, for the choice of included patients. For example, patients were eligible only if pre-

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BMJ 2005;330:1220-1