QUALITY
IN HEALTH
CARE

Editorial

Leadership and learning: building the environment for better, safer health care

Leadership in health care carries enormous responsibility. Effective leadership is crucial for good, effective, and safe care. It has recently been reported that a "breakdown" of leadership was partly responsible for the collapse of one of the UK's heart and lung transplant programmes and, by implication, a higher than expected death rate.[1 2] The link between good leadership and the quality of health care is neither new nor surprising. Leaders function within the context of teams, systems, and organisations, and the delivery of good and safe care depends, too, on how well these teams and systems work. The message this carries to healthcare education is that, as well as learning about the care and management of individual patients, practitioners should acquire the skills to enable them to work effectively with others and to understand, care for and, when necessary, change the system of care.[3] Not to do so is to put patients at risk of harm.

The world does not fall neatly into categories of leaders and followers. All who work in health must understand the impact and implications of leadership; leaders exist at many levels—and especially so in a system as complex as health care. Individuals may be required to lead in some situations but, at other times, to take up important team roles. The Chief Executive may have overall responsibility for the functioning of a hospital, but a surgical team undertaking complex risky surgery will be led by a surgeon. That surgeon may also be a member of the hospital's infection control team led by a microbiologist or a clinical nurse specialist. Doctors have traditionally been seen as the clinical leaders, but often it may be preferable or necessary for another healthcare professional to take the leadership role.

Much has been written on leadership—including more than 2000 books in 1999 alone.[4] The profiles of individual leaders and many books about leadership on airport bookstands reflect a general view that "good" leadership is important for "effective" businesses. Understanding the complexity of leadership is important. While leaders will share some characteristics such as providing vision, direction and motivation, leadership research also describes different styles and approaches. Maintaining the status quo, managing and measuring the system, for example, through performance monitoring, audit, and error reporting demands a "transactional" style of leadership, but in circumstances of significant change a "transformational leadership approach" may be more effective. Individuals have their own preferred style and methods, but healthcare leaders at all levels should be capable of moving between styles, depending on the contingency or context.

Chief executives, perhaps the most prominent and exposed leaders in health care, now have the additional overriding responsibility for the quality and safety of patient care. Many are leading significant organisational change, establishing different ways of working that may require huge cultural change within professional groups. Models of leadership from the (less complex) private sector are not always helpful in the context of health care. An examination of conflicts and tensions—such as the individual professional versus the team; professional accountability versus organisational corporate performance; quality versus efficiency; clinical versus non-clinical imperatives—reveals some of the difficulties.

Good leadership can influence an organisation to operate effectively as a "learning organisation"—that is, one that is adaptive and responsive to changes both from within and without. In such organisations there is a strong sense of direction and, crucially, attention is paid to the roles and development of the workforce. Individual learning improves the way people work together and function as teams and makes the systems of care more effective. People working within such organisations constantly use new information about their work to improve performance.[5 6]

The papers published in this supplement have been prepared for the conference on "Leadership and learning: just what does it take to improve the quality of care?" organised by the Nuffield Trust, the BMJ Publishing Group, and *Quality in Health Care*. One of the aims of the conference is to explore some of the human factors that make the system of health care work as it does, and to identify the changes needed if we are to be able to guarantee better quality, safer care to our patients and clients. Making significant and sustained changes to the way we work will require changes in the way in which practitioners are prepared for their increasingly demanding and complex roles.

Many aspects of the healthcare system are undergoing profound change. Patient expectations, technological advances, the drive to improve the safety and the quality of care, and the need for accountability are challenging traditional professional and managerial systems, approaches, and attitudes. More than ever there is a need to appraise the systems of care and to make them fit for their purpose. The importance of leaders, teams, and organisational functions to the delivery of good, safe care

necessitates examination of the preparedness of all healthcare professionals for working within a complex system. This will confront many deep assumptions about professions and professionalism. However, without providing practitioners with appropriate skills, we may not only fail to foster best patient care, but are unlikely to develop tomorrow's leaders capable of managing ever increasing complexity.

The failure of leadership in that transplant unit may perhaps be described as a failure of education. Has anyone asked about the training and guidance in, for example, leadership, team working, risk management, or change management available to the members of those teams? How well do undergraduate and postgraduate training programmes prepare practitioners to fulfil all aspects of their roles? Until that sort of question is being asked—and answered—more often and more openly, we will continue to read of sad descriptions of failed units and of the inevitable avoidable harm to patients.

FIONA MOSS

Editor, QHC

PAM GARSIDE

Associate Editor, QHC

1 Laurance J. Transplant unit condemned for 70% death rate. *The Independent* 13 September 2001, 16.
2 Commission for Health Improvement. *Investigation into heart and lung transplantation at St George's Healthcare NHS Trust*. London: Commission for Health Improvement, 12 September 2001 (www.chi.nhs.uk/eng/organisations/london/stgeorges/index.shtml).
3 Berwick D, Enthoven A, Bunker JP. Quality management in the NHS: the doctor's role. *BMJ* 1992;**304**:235–9.
4 Goffee R, Jones G. Why should anyone be led by you? *Harvard Business Review* 2000; September/October: 63–70.
5 Garside P. The learning organisation: a necessary setting for improving care? *Quality in Health Care* 1999;**8**:211.
6 Argyris C, Schon DA. *Organisational learning: a theory of action perspective*. Reading, MA: Addison Wesley, 1978.