Malcolm Clarke has succeeded in speeding up patients' access to minor orthopaedic procedures – by performing them himself. He told Catharine Sadler about the work that has won him the Nursing Standard Nurse 2000 Surgical Nursing Award.

Smooth operator

Govern, masked and watchfully anticipating the surgeon's next request, the operating theatre nurse's role is skilled and supportive. But is it a position with potential for growth? Malcolm Clarke began questioning his 'handmaiden' role in theatres some years ago. Now an operating nurse specialist, he has significantly reduced Leicester General Hospital's orthopaedic waiting list by booking in and performing almost 250 minor surgical operations in the past 18 months.

'Over the years, I have learned a lot about theatre nursing and enjoyed watching and working with surgeons,' says Mr Clarke. 'But as my role increasingly involved monitoring waiting lists and assisting trainee doctors carry out minor surgery, I questioned whether our patients were getting the best service we could offer.

Opposition

'For example, someone whose hand mobility, employment and quality of life was seriously restricted by the pain and incapacity of carpal tunnel syndrome (CTS) might have to wait two years for a minor operation, which would then be carried out by an inexperienced doctor. So I thought I could be operating on them at least as well myself.'

Having developed a rapport with orthopaedic surgeons over the years, Mr Clarke put his idea to them. 'I was pleasantly surprised by their response. They suggested a list of minor orthopaedic operations they believed I could perform with some additional training. These included carpal tunnel decompression, release of trigger finger and other minor orthopaedic operations,' his director of nursing was equally enthusiastic.

But this was the easy bit. Mr Clarke's training plan had to be approved by the hospital's multidisciplinary risk committee. And not everyone shared his enthusiasm for the project.

'At that stage, some of my nursing colleagues were sceptical, believing that extending my role might be too challenging. Junior doctors and anaesthetists on the committee also had initial reservations about my competence. But the strongest objections came from two surgical bodies, the British Orthopaedic Association (BOA) and the British Hand Society (BHS), both of which were absolutely against my plan. They viewed any shortened surgical training scheme as an infringement of their professional guidelines,' he says.

But once Mr Clarke convinced the risk committee he had the required ability, they allowed him to embark on a training plan to treat patients with CTS, from referral and diagnosis, through surgery and follow up, to final discharge.

Since July 1999, Mr Clarke has carried out almost 250 minor orthopaedic operations. But his achievements are more than technical. By booking patients for surgery at a time which suits them and liaising with the private sector to speed up diagnostic investigations, Mr Clarke has both accelerated referral times, provided patients with continuity of care and saved his trust money.

Dates to suit patients

'Before taking up my post, I noticed that our surgical waiting list system was slow because patients were not turning up for their appointments. Asking patients to name an operation date that suits them resolved this,' says Mr Clarke.

'And by running two nurse-led evening outpatient clinics a week, I am able to see about 90 patients a month. These clinics suit younger patients, who do not like taking time off work for a day time appointment,' he adds.

A shortage of electromyography (EMG) equipment - essential for accurate CTS diagnosis - had also been increasing waiting lists. So, on his own initiative, Mr Clarke bypassed the hold-up: 'By liaising with the private sector to use their EMG facilities, I have negotiated a fee £10 cheaper per patient than that of the NHS. As a result, everyone is happier; the patients are pleased to be treated sooner, the private sector gains and our trust has saved money and reduced waiting times.'

As Mr Clarke's patients do not need day-case beds, they are easily accommodated in existing theatre space, enabling him to operate on...
Auditing the outcomes

But have those who initially questioned Mr Clarke’s ability been reassured of his competence? ‘Our hospital risk committee allowed me to extend my role in this way, provided I met certain conditions. These included close supervision by a surgeon and an audit of my work, which I am about to present. Objections by the BOA and BHS were overruled by the hospital trust, which took full responsibility for my role extension. I will be presenting my audited results to the BHS at a conference in June. My nursing colleagues soon overcame their initial reservations and, keen to ensure the success of a nurse-led initiative, support me in my new role.’

Auditing the outcomes of his assessment, treatment and patient care has been one of Mr Clarke’s priorities from day one. He uses the Levine Carpal Tunnel scoring system, which orthopaedic experts and professional bodies such as the BHS and BOS use to monitor both symptom severity and function. Recorded before and after hand surgery, the mean results show a post-operative decrease in CTS symptoms and an increase in hand function. These scores, claims Mr Clarke, are similar to those of orthopaedic surgeons.

Patient feedback is also good, according to results from a patient evaluation measure also used by orthopaedic experts. Says Mr Clarke: ‘My patients were happy with their treatment and said they would recommend the service to their friends and family. They also praised the flexibility of the system.’

It could be argued that by becoming a ‘mini surgeon’, Mr Clarke has turned his back on his nursing skills. On the contrary, he says, his nurse training has assisted him in his new role. ‘Unlike many doctors, most nurses have buckets of empathy for their patients and their training makes them good listeners. Patients have praised the informality of my consultations and my ability to put them at their ease. This is where the benefits of continuity of care become apparent. Having met before surgery, and knowing we will meet afterwards, my patients and I have an excellent rapport during their operation and we usually chat away about everything.’

A new scheme

Incredibly, Mr Clarke already has a new scheme in the pipeline. ‘Two groups of NHS orthopaedic waiting-list patients get a raw deal. Those with debilitating minor conditions like CTS and older people who, until recently, have had to wait up to 18 months for knee-replacement surgery,’ he says.

Unable to perform joint-replacement surgery himself, Mr Clarke is able to act as an efficient link between patient and surgeon. ‘Within two weeks of referral, I see potential knee-surgery patients for a 40-minute appointment, during which I assess their level of disability and discuss their surgery and its chance of success. Although my findings are discussed with the surgeon, his time has been saved and by enabling the older patient to make an informed decision quickly, we have reduced waiting times to just five months,’ he says.

So does Mr Clarke have a message for nurses like him, who feel that by extending their role imaginatively, they can speed up and improve the treatment and care of today’s patients?

‘I believe our NHS has lost its way by squandering money on layers of management and forgetting that we, the health professionals, are here to help patients. So any nurses who feel they have the energy and ability to extend their role must first access someone who knows them and their work, ensure they are covered professionally, then go for it. By taking the long view and seeing what they will be gaining for their patients, they will succeed against all odds.’

Catharine Sadler is a freelance writer.