European Working Time Directive legislation

Developing and implementing organisational practice that delivers better, safer care

W Reid

The impact of organisational changes such as the European Working Time Directive on doctors' hours should be evaluated in terms of its effect on the quality and safety of patient care

Significant improvements in patient care usually require major organisational change. In reality, this inevitably means disruption and upheaval of working practices that have evolved over decades. The prospect of change creates uncertainty and an inertia that gets in the way of progress and improvement. Arguments for the status quo can often supersede the argument for change.

In the UK—and presumably throughout Europe too—hospitals are being thoroughly exercised by the urgent need to implement the European Working Time Directive (EWTD).[1] This states that the working week must be limited to 48 hours. Because doctors have traditionally worked excessively long hours, the EWTD is being applied to them in stages. But, by 1 August 2004, doctors may only work 58 hours per week. The EWTD is set within the framework of Health and Safety at Work legislation. This makes sense. Long hours of work contribute to high stress levels within the profession[2] and overwork is a factor in adverse clinical incidents.[3] And it must be healthier to work for 58 than for 100 hours per week.

The organisational changes needed to create systems in which doctors' working hours are within the limits set by the EWTD are enormous. Even some of the least radical changes that have been proposed—such as the move from on call rotas to shift work—have caused anxiety that the alterations to working practice will create "risks to patient care". Specifically, there are worries that shift working will cause a "loss of continuity of care" and reduction in time available for training. The inevitability of the introduction of the EWTD—which, unlike other directives on doctors' working hours, is in a legislative framework—has concentrated minds on solutions to these concerns. So, well directed, formal handovers have been championed as the "organisational antidote" that will preserve or even strengthen continuity of care. The huge clinical and educational benefits of working within functional teams are now being understood. Shorter hours with new styles of work are recognised as compensating for the loss of the apprenticeship approach to experiential learning that was the norm. More of the training curricula will have to be taught, not simply experienced, and the competencies claimed will be assessed to a common standard.

Nevertheless, there remain many anxieties about these changes and the impact on the quality of patient care. But trying to "solve" the problem of doctors' hours in isolation from the whole healthcare system is a mistake. If the ultimate goal is to create systems in which patient care can be delivered well and safely, then care needs to been seen as a whole rather than in its constituent parts. Moreover, as health care changes, we need to develop systems that are appropriate for today's health care and will benefit patient care. An example of the sort of change that has an impact on patient care is described in two papers in this issue of QSHC.[4 5] Medical emergency teams (METs) are multiprofessional teams that can be activated by any member of the hospital staff who sees grave clinical deterioration. The impact on patient care was clear: as MET calls increased, cardiac arrests fell from 6.5 to 5.4 per 1000 admissions. The introduction of these teams is something that all acute hospitals need to consider, and the basis for doing so is clearly of benefit to patient care. Despite the potential advantages to patients, the implementation of this organisational change to traditional working patterns was not straightforward. Ensuring appropriate utilisation was difficult because of "cultural" barriers. It seems that those traditional hierarchical behaviours that dictate how doctors and nurses react and work got in the way of people calling these life saving teams.

It is just this sort of organisational change which has a clear emphasis on what works for patients that should be considered within the context of EWTD. In the UK some hospitals are taking an organisational approach to the challenge of EWTD by working out what work done at night is essential and then putting into place multiprofessional night teams staffed with people who have the range of relevant competencies.[6] Implicit in these "hospital at night" projects is the assumption that the work that should be done in the day must be done in the day, and that we need to move away from traditional ways of organising work. Teams need to be established that are linked to patient care. All characteristics of good team functioning—including leadership, communication, and shared goals—need to be understood and put into practice.

Traditional hierarchical consultant led teams rely on fixed points of contact such as the consultant ward and informal reporting "up the line". Teamwork in this long established medical sense is perhaps better described as "didactic leadership". This worked very well in the past but is now less effective and too cumbersome, fragmented, and insecure to maintain good care and clear communication, especially when several doctors of the same grade are responsible to one consultant. Moreover, the combination of the drive to reduce hours and increasing sub-specialisation has increased the number of doctors seen by an individual patient in one admission. Too many people in the decision making hierarchy can cause potentially harmful diagnostic or therapeutic delays. In complex clinical situations, standardised shared protocols are safer than multiple individual approaches to decision making. Despite these arguments, it will be difficult to move away from well established working practices, even if they are well past their "use by date".

Meeting the requirements of the EWTD is daunting, but there is an accruing amount of experience that can be used to inform the necessary changes. The MET study is one of these. It demonstrates one approach to organising patient care that may be of direct relevance. It also shows that implementation will be tough; old habits die hard. But a crucial lesson which we should all take from this study is the importance of evaluating the impact of any such change in terms of its effect on the quality and safety of patient care. The argument for new ways of working, such as the "hospital at night" project, will only be won when it can be shown that there are clear benefits to patients. EWTD legislation aims to improve the

lives of doctors and other healthcare staff. It will only achieve this if we can also define processes that provide better care.

Correspondence to: Dr W Reid, London Deanery, 20 Guilford Street, London WC1N 1DZ, UK; wreid@londondeanery.ac.uk

REFERENCES

1 **Department of Health**. *European Working Time Directive*, HSC 2003/2004. London: Department of Health, 2004.
2 **Firth-Cozens J**, Cording H. What matters more in patient care? Giving doctors shorter hours of work or a good night's sleep? *Qual Saf Health Care* 2004;**13**:165–6.
3 **Firth-Cozens J**, Greenhalgh J. Doctors' perceptions of links between stress and lowered clinical care. *Soc Sci Med* 1997;**44**:1017–22.
4 **DeVita MA**, Braithwaite RS, Mahidhara R, *et al.* Use of medical emergency team responses to reduce hospital cardiopulmonary arrests. *Qual Saf Health Care* 2004;**13**:251–4.
5 **Braithwaite RS**, DeVita MA, Mahidhara R, *et al.* Use of medical emergency team (MET) responses to detect medical errors. *Qual Saf Health Care* 2004;**13**:255–9.
6 **Cass HD**, Smith I, Unthank C, *et al.* Improving compliance with requirements on junior doctors' hours. *BMJ* 2003;**327**:270–3.

Quality indicators
....

Developing quality indicators to assess quality of care

A Clarke, M Rao

....

Different measures of quality require different methods

In our era of "assessment and accountability" in health services it is important to be able to assess quality. Much has been written about measuring quality and quality assessment,[1][2] and there are some valuable and well known frameworks available for doing this.[3][4] Quality frameworks tend to include a number of different dimensions. It is clear that the concept of quality must be multidimensional but it is surprisingly difficult to map the frameworks onto each other.

Maxwell[3] offers us an apparently comprehensive six dimensional framework (effectiveness, efficiency, equity, acceptability, appropriateness, and accessibility) which can be used to assess the quality of health services but, in Maxwell's framework, certain key and essential elements such as (Donabedian's) structure and process[4] or attention to a more holistic approach to anticipatory health care offered to the individual are omitted.

Toon's framework[5] for conceptualising quality in the primary care setting in the UK is less well known. It includes four dimensions of quality: biomedical, business, teleological, and anticipatory. The biomedical dimension relates to the technical quality of care—how well care is offered from the point of view of known effective and appropriate interventions; the teleological dimension is related to the acceptability and humanity of care; the business dimension is about process and efficiency; and the anticipatory dimension is about offering holistic care—not just dealing with expressed demand but also with unmet need.

It is possible that frameworks differ because of fundamental differences in conceptualising the measurement of quality. For example, among health service researchers and practitioners there is a strongly held view that it is more appropriate to measure the processes than the outcomes or the effectiveness of individual services, since evidence based care is all about assessment of the appropriate circumstances in which to apply known effective interventions.

This is the approach taken by Steel *et al*[6] in their paper in this issue of *QSHC* on developing quality indicators for older adults, where a number of evidence based criteria developed in the US have been adapted for use in the UK. The paper lists 119 potential quality indicators derived by Wenger *et al*[7] using the evidence and consensus development methods, 102 of which were rated as applicable to the UK situation by a panel of experts.

But is this a reasonable approach? Known effective interventions may be misapplied or used in inappropriate or unsympathetic settings. Some would argue that outcomes or effectiveness are what matters and that processes may be immaterial so long as good outcomes can be achieved. However, there are drawbacks to this approach too. Good outcomes can result from inappropriate care. A very low mortality may result from unnecessary surgical intervention. As Brook *et al* point out,[2] not all poor processes result in poor outcomes.

It is possible that both of these "mainly process" or "mainly outcome" approaches pay inadequate attention to the views of patients who may be concerned with the humanity, acceptability, equity, or potentially more holistic nature of health care and the need to reflect these dimensions in quality assessment. Of course these are to a certain extent secondary dimensions, since there is no point in offering ineffective care more equitably or more humanely. But one of the reasons for the apparent mismatch between quality frameworks may be that "quality" of services depends on one's viewpoint.[8]

It appears then that there may be differing viewpoints from which quality frameworks are constructed and used—the population perspective; the external auditor or evaluator's perspective; the individual practitioner, patient or carer perspective; the payer perspective. Frameworks may differ because of these differences of perspective. And although it might be thought that an ideal framework for assessment of quality would incorporate all the essential elements from the different frameworks, it is likely that this might make for an unwieldy and potentially unusable quality measuring tool.

Wenger *et al* developed the original quality indicators for use in assessing the quality of clinical care for vulnerable elderly people in the US,[7] and they occasionally used telephone interviews with patients to assess whether the care provider had complied with the quality indicators. Steel *et al* suggest that this might be a good idea in the UK because case note review is often difficult and time consuming. It is important, however, that, if these quality indicators are to be used in the UK in interviews with individuals, then they should be independently validated for that purpose with elderly people and with their carers. There is currently little evidence to support the contention that the technical quality of care is best assessed by patients themselves. To what extent are the proposed quality indicators comprehensible and assessable by means of an interview? To what extent do they relate to the concerns of the elderly people themselves? It may be that issues relating to humanity, acceptability, equity, or the holistic nature of health care are not covered—but they are key concerns of elderly people.

The objectives, the viewpoint, and the potential costs and drawbacks as well as the potential benefits of any quality assessment need to be very clearly understood before it is undertaken. The quality indicators developed by Steel *et al* are a good start, but they will need more