

QUALITY IN HEALTH CARE

Editorials

Multidisciplinary teamwork: the good, bad, and everything in between

See article on page 70

Teams make up the building blocks of health care and every team—from the executive to the coal face—is composed of different professionals, ideally possessing a variety of skills necessary to produce safe and effective care.¹ We are constantly reminded of the value of diversity within teams, but the reality is that working together from a variety of perspectives is sometimes difficult to achieve. The paper by Jenkins *et al*² in this issue of *Quality in Health Care* shows, for example, that, unless roles are well defined and understood, responsibility for giving different types of information to patients could easily result in overload to the patient, differences in messages, and gaps in certain areas.

The difficulties of multidisciplinary teamwork are also apparent in differing attitudes towards the way to bring about a good outcome, and even what actually constitutes a good outcome. For example, in teams caring for patients with stroke there are a number of “ideal outcomes” from the various stakeholders and staff involved—complete mobility is desired by the patient, physical immobility but good mental ability by the carer, compliance with the regime is required from some health workers, and (I have heard say) death from the contracts manager. Just as feedback from the cancer team audit would be helpful in producing better communication in the future,² so discussing different approaches to care and differing ideas of best outcome will also keep the team on what is inevitably a wavy line along the best practice meridian.

What makes healthcare teams so different from those in other types of organisation is that team members have differing allegiances, not only to the team but also to their professional groups. For example, if a member of the nursing staff abuses a patient on a psychiatric ward, who has ultimate authority to deal with this—the nursing line manager or the consultant psychiatrist who is seen by some as the team leader? In commercial organisations such questions would be easily answered, but history and professionalism play their part in making questions of authority and responsibility in the health service team much more complex.³ Reinforcement of the supra-goal—patient safety—can help to push people beyond professional barriers, but clarity about authority and accountability in health care teams is long overdue.

There is another warning to heed against complacency in terms of teams: in these days of constant measurement and the drive towards reporting of poor care,⁴ we need to look beyond the data laid before us. A study by Edmondson⁵ on medication errors in nursing teams showed that

poor teams produced fewer errors; however, poor teams had authoritarian team leaders and so the likely explanation for this surprising finding is that data were being manipulated in poor teams and shown honestly in good open communicating teams. Clearly, teams need to be rewarded for their reporting systems and use of feedback rather than for the data alone.

These are not issues to dodge, but neither do they make good multidisciplinary teamwork an impossible task to achieve. Such teams are the reality that we work in and, although rarely captured in data, their diversity does actually help patient care.⁶ It is possible that this happens because of the increasing findings which show that members of good teams are significantly less stressed than others.⁷ Moreover, in a study of house officers, those who appreciated that they were part of a multidisciplinary team (as opposed to simply being bottom of a medical hierarchy) had far lower stress levels than those who did not,⁸ probably because they were able to learn from the diversity of skills that surrounded them and could look further than their medical colleagues for support. Since we know that lower stress means better patient care,⁹ it is also likely (as well as common sense) that better teams produce better care through having more cheerful staff, probably through their greater sense of participation and support. Somewhere in this equation lies the issue of sufficient resources—sufficient to allow time for good communication within the team and with the patient.

So multidisciplinary teams are likely to be better for everyone, but to keep them working well needs skill as well as recognition that this is always a long term task requiring constant attention and adjustment. Good team leaders are essential for maintaining patient safety¹ and the sooner we get them the training and support they need for this task, the better the quality of care is likely to be.

J FIRTH-COZENS

Director, Centre for Clinical Psychology,
University of Northumbria at Newcastle,
Newcastle upon Tyne NE7 7AX, UK
jemmy.firth-cozens@unn.ac.uk

- 1 Firth-Cozens J. Cultures for effective learning. In: Vincent C, ed. *Clinical risk management*. London: BMJ Books, 2001: 355–68.
- 2 Jenkins VA, Fallowfield LJ, Poole K. Are members of multidisciplinary teams in breast cancer aware of each others' informational roles? *Quality in Health Care* 2001;10:70–5.
- 3 Stokes J. Institutional chaos and personal stress. In: Obholzer A, Zagier Roberts V, eds. *The unconscious at work: individual and organizational stress in human services*. London: Routledge, 1995: 121–8.

- 4 Department of Health. *An organisation with a memory: report of the expert group on learning from adverse events in the NHS*. London: Department of Health, 2000.
- 5 Edmondson AC. Learning from mistakes is easier said than done: group and organizational influences on the detection and correction of human error. *J Appl Behav Sci* 1996;32:5–28.
- 6 Adorian D, Silverberg DS, Tomer D, *et al*. Group discussions with the health care team: a method of improving care of hypertension in general practice. *J Hum Hypertens* 1990;4:265–8.
- 7 Carter AJ, West MA. Sharing the burden: team work in health care setting. In: Firth-Cozens J, Payne RL, eds. *Stress in health professionals: psychological and organizational causes and interventions*. Chichester: John Wiley, 1999: 191–202.
- 8 Firth-Cozens J, Rayner C. *Training in the pre-registration house officer year*. Report to North Thames Department of Postgraduate Medicine and Dental Education, 2000.
- 9 Firth-Cozens J. Interventions to improve physicians' well-being and patient care. *Soc Sci Med* 2001;52:215–22.

Choosing effective strategies for quality improvement

See article on page 76

Since 1998 the UK government has developed a comprehensive strategy for quality improvement for the National Health Service (NHS). This includes national guidelines and standards for clinical care, a national system of inspection and monitoring, and a requirement for all NHS organisations to implement quality improvement strategies. A clinician has been appointed with responsibility for quality improvement within every NHS organisation (the clinical governance lead), but these doctors and nurses have been given little specific guidance on what actually to do. The choice of quality improvement strategies is largely for local leaders to decide.

What does the literature suggest is most likely to be effective? On the whole, single interventions have relatively little effect. Simply distributing guidelines or educational material rarely changes clinical behaviour.¹ These may be more successful if combined with audit with feedback, computerised prompts, or academic detailing.^{2–5} Financial incentives can produce change,⁶ but are a blunt instrument and risk producing perverse incentives. Multiple interventions are generally more effective than single ones.⁷ Substantial claims are made for continuous quality improvement or total quality management strategies,^{8–9} but there is little clarity about the circumstances in which they produce major change.^{10–11} Information on quality of care which is released to the public is mistrusted by doctors, but making information available may stimulate provider organisations to change care.¹²

Given an imperative from the UK government to do something, and a certain amount of guidance from past research on what is likely to work, we now have information from both primary and secondary care on what is actually being done. In this issue of *Quality in Health Care* Wallace and colleagues report the results of a survey of 86 hospital trusts.¹³ Virtually all had implemented educational programmes, had developed local protocols or guidelines for care, and had established local quality improvement groups. These were followed closely by formal or informal assessment of care by peers. Feedback of performance data was being used in just over half. Campbell *et al*¹⁴ have reported the results of a comparable survey in primary care. Educational activities were again the most commonly reported and in over half the primary care groups surveyed, the whole primary care group (approximately 50 doctors) was closing for one afternoon a month for joint educational activity—a major cultural change for UK general practitioners. Joint audits across practices were common, with half of the groups surveyed feeding back or planning to feed back identifiable comparative information. Unlike the survey of hospital trusts, more than half were providing financial incentives linked to quality improvement.

Wallace *et al* asked their respondents whether these strategies are likely to be effective. Despite the effort put

into educational programmes and guideline development, fewer than half the respondents perceived these to be effective approaches—a view supported by the literature. Creating clinical groups to focus on specific issues was regarded as the most effective of the techniques being used. Clinical governance leads are faced with a paradox. They are under strong pressure to demonstrate activity. Yet some of the things which the literature shows to be most effective agents for change—such as academic detailing—are also heavily resource intensive. Both surveys indicate that modern approaches to behavioural change are being used, with active involvement of clinicians high on the list; in Campbell's survey over 90% were encouraging the development of personal learning plans by general practitioners. What is clear from both surveys is that a range of simultaneous techniques are being used, which is consistent with the literature on multifaceted interventions being more effective than single ones. This was certainly the experience of one recent quality improvement initiative in UK primary care where major changes in behaviour appeared to have been brought about by a combination of clear leadership and a range of financial and professional incentives.¹⁵

So what can be made of progress so far? There is no doubt that much activity has taken place. This is perhaps not surprising since a legal “duty for quality” has been put on NHS organisations, and chief executives of NHS trusts can probably expect to lose their jobs where serious deficiencies of quality are found. A wide range of quality improvement activities are now reported, many of which are at least compatible with the literature on interventions likely to produce change. We do not know how the activities reported by clinical governance leads reflect actual change on the ground, or even whether the respondents have the ability to know if such change is taking place—development of IT systems to monitor quality are a high priority across the NHS, but currently they are woefully inadequate. Likewise, we do not know whether those clinicians who have volunteered for roles as clinical governance leads have the experience of organisational change that is needed for them to be effective. In response to this potential deficit, the NHS has started a development programme for quality improvement leaders.

In terms of top down strategy, the UK NHS probably has the most ambitious quality improvement strategy in the developed world. Local leaders have been appointed throughout the NHS with freedom to develop a range of quality improvement programmes, though with no option to do nothing. In terms of actual results it is too early to tell whether the strategy is being successful. Activities reported so far are limited by the resources available, and clinical governance leads identify lack of time and resource as the major barriers to progress. The success of the policy is likely to depend on whether there is continued investment in an