QUALITY IN HEALTH CARE

Editorial

Quality improvement: a multiprofessional commodity?

Two logos, those of the Royal College of Nursing and the British Medical Association, appear on this issue of *Quality in Health Care* and symbolise the commitment of two professional groups – nursing and medicine – to work together to promote greater dialogue and exchange of ideas on the topic of quality improvement. But a logo on the cover of a journal will not necessarily influence its contributors or its contents.

One of the expressed aims of this *Journal* is to encourage both readers and authors from all healthcare professions.^{1,2} Good quality care and quality improvement are so clearly dependent on collaboration between different healthcare professionals that a journal that publishes work relevant to quality improvement should expect to publish papers from a range of professionals. But of the 498 contributors to papers published in this *Journal* over four years only 28 (6%) are nurses. Most are doctors (45%) or health service researchers (34%). Only a few authors are from other healthcare professions: 13 pharmacists; 11 psychologists; four representatives from professions allied to medicine, and 14 health service managers. Looking at these data in another way, nurses have contributed to 18 papers. For 10 of these nurses have been part of multidisciplinary joint authorships – with a nurse as lead author in one. All authors of three papers were nurses and five editorials were written by a nurse as sole author.

From these figures it seems that few nurses involved in quality improvement and in multidisciplinary audit initiatives are submitting their work to this *Journal*. Or, if the papers that appear in this *Journal* reflect what is happening in the field of quality improvement in the United Kingdom, then clinical audits done without the involvement of nurses or physiotherapists or managers or pharmacists significantly outweigh those done within a multidisciplinary framework.

In the United Kingdom the Department of Health emphasises the importance of multiprofessional involvement in clinical audit, clinical guidelines, and clinical effectiveness. But it seems that rhetoric is way ahead of reality and we continue to work within professional boundaries. How can we change?

Culture and values

It is in the nature of the healthcare professions that the expertise of each is focused on a narrow set of activities. Together these activities make up the package of complete patient care. Different ideologies and values have become attached to each profession. Methods of quality improvement such as clinical audit need to be used to assess the work done by each group. But quality improvement should be the stimulus for getting beyond professional boundaries. Not only should quality improvement work include assessment of the complete

packages of care but also should enable the different healthcare professionals to understand the work and the values of colleagues from other professions.

In a world of shifting and diminishing resources for health care there is a strong pull towards quantitative and economic aspects of health care at the expense of the more qualitative aspects of caring.³ Thus clinical audits that look at the use of medical interventions may seem to be more relevant than the investigation of, say, autonomy and basic dignity. But to include within the remit of quality improvement only assessments of the success of clinical interventions would be to construct a narrow view of healthcare "... compatible with the possibility of accepting that all was well with the quality of care in a colony of slaves".⁴

The choice is straightforward enough: do we use quality improvement tools such as clinical audit to promote a humane and effective healthcare system or do we tinker around with bits of it, narrowly defining what we mean by quality so that we can show some success? Nurses and doctors may be pulled in different directions on these issues. There are many perspectives that must find a place in clinical audit and in quality improvement: whether about investigation of the appropriateness of use of clinical interventions; about the process of management of postoperative pain; about investigating why patients on some wards are woken to take drugs at 6.00 am; or concern about the quality of informed consent.

Structures and resources

Nurses have experienced profound changes in the structure and resourcing of their services and in the United Kingdom this has contributed to their difficulty in getting involved in clinical audit. The effects of continued reductions in the numbers of senior clinical nurses, of qualified nurses on duty at any one time, and in the handover period between shifts have been exacerbated by increased patient throughput and increased workload. Nurses have taken on tasks formerly done by doctors as well as additional managerial duties and more clinical supervision.

In these circumstances it is hardly surprising that nurses have not written about their experience of quality improvement. There simply has not been time. But of greater concern must be the likelihood that because of increased pressures within the healthcare system nurses and other healthcare professionals have not been able to engage in clinical audit or quality improvement work.

Doctors, in both hospital and primary care, also experience increasing pressures. Many took on the work involved in medical audit when it was introduced into the United Kingdom in 1989. But, despite the rhetoric, and many think good intention, nobody it seems has had the

time to do more than make a notional move from medical to multidisciplinary audit. There is a need in many places to alter uniprofessional audit structures to facilitate the inclusion of nurses and others.⁵ Clinical audit committees in hospitals and medical audit advisory groups in primary care continue mostly to be run by doctors.⁶⁻⁸ Thus in the United Kingdom quality improvement in the form of clinical audit has mostly followed traditional decision making and resourcing structures.

Practical approaches

Clinical audit, as a method, is relatively straightforward; it is the process of getting teams to work together that makes it difficult. Nursing colleagues who have experienced successful multidisciplinary audit attribute its success to various factors including: qualified nursing staff working as colleagues with medical staff; respect between senior nurses and senior doctors; nurses able confidently to articulate their case and argue points; doctors who value the contribution of other team members; and the presence of trained facilitators. Effective teamwork at local level is dependent on the organisational climate, the long term commitment to quality, and the preparation and planning surrounding staff training and development.⁹ Research into nursing audit initiatives tell the same story.¹⁰⁻¹² The evidence indicates that there is much work to be done to improve team functioning but perhaps the first step should be at least to create conditions in which doctors and nurses have time to talk to each other.

The reasons why nurses do not contribute to this *Journal* may sound overwhelmingly gloomy. But despite all the difficulties, I know that many nurses both in the United Kingdom and elsewhere are actively involved in quality improvement and clinical audit work. And their contributions are important. We know that slowly and often with difficulty healthcare professionals are beginning to consider issues of quality together, as teams.

Looking forward

In considering the difficulties of transferring ideas about quality improvement and writing about such work for an international readership, Grol suggested that we should "look beyond parochial boundaries and be prepared to explain our own work so that it is accessible to colleagues from other countries".¹³ Perhaps healthcare professionals need to write about their work and experiences so that we all can appreciate different perspectives on quality in patient care.

If this *Journal* is to meet its aim of being multiprofessional we do need to receive contributions from nurses and other healthcare professionals and managers. In this issue a paper by Thomas and colleagues

describes their work on the development of scales to measure satisfaction with nursing in acute care (pages 67-72).¹⁴ And this should be of interest not only to nurses but to people from other professions.

The link between the Royal College of Nursing and this *Journal* should help us introduce more nurses to *Quality in Health Care* and encourage them to submit their work. All potential contributors should be aware of the *Journal's* structure and the types of papers that are published in addition to original research papers. These include quality improvement reports that describe experiences of clinical audit and other quality improvement work and viewpoints and opinions that enable discussion and debate about quality in health care. And we ask those considering writing about their work to reflect on who has contributed to the work and consider fairly who should be involved as authors.

That this *Journal* has not yet succeeded in its aim of being multiprofessional should not detract from the importance of the partnership between nurses and doctors and other members of the healthcare team. That this sort of dialogue is necessary is possibly the most important factor in moving forward to a truly integrated view of quality in patient care.

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