



ORCAB special series

Improving quality and safety in the hospital: The link between organizational culture, burnout, and quality of care

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The need to improve quality of care represents a major goal of all health care systems. The objective of this series is to illuminate how the contextual factors of hospitals from eight European countries, and the well-being of their healthcare professionals, contribute to either construct or degrade quality of care. The studies reported here provide an important bottom-up perspective on quality of care, and the way that burnout and organizational culture are intertwined within it. Overall, the collected studies represent an in-depth examination through focus groups of the experiences of 153 physicians, 133 nurses, and 46 patients from Greece, Portugal, Bulgaria, Romania, Ireland, Turkey, Croatia, and the Republic of Macedonia. Each paper makes a unique contribution to the understanding of how institutional contexts, organizational management, and job characteristics impose constraints, both on the capacity of health workers for better treatment decisions and choices, but also on their day-to-day professional satisfaction and quality of life. Taken as a whole, the papers make an even greater contribution, by pointing out the underlying similarities and differences across these eight European countries.

Statement of contribution

What is already known on this subject?

- Organizational factors play a crucial role in the development of health professionals' job burnout, which in turn impacts the patient experience and quality of care.

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What does this study add?

- We discuss the impact of highly contextualized organizational cultures in hospitals from eight European countries on health professionals' burnout and quality of medical care.
- Despite the diversity of the countries reporting research data, significant patterns with regard to quality of care and job strain were identified.
- We propose that improving quality of care requires not only the understanding of the clinical environment, health workers' motivation and commitment, but also patients' needs and literacy, health policy, and the social and political context in which health services are delivered.

It is widely accepted that organizational culture has a role to play in the development of job burnout, which in turn impacts on the patient experience, and ultimately results in quality of care that is not optimal. Put even more simply, patient care is undermined when healthcare professionals (HPs) have poor work environments. However, despite this knowledge, the links between these three factors have not been systematically assessed. For example, despite the very large volume of literature on quality-of-care improvements, there is a paucity of hospital interventions with a theoretically based design or implementation (Conroy *et al.*, 2012). In addition, the initiatives that do exist are rarely designed or developed with regard to the individual and organizational factors that determine the success or failure of such initiatives. Congruent with the aforementioned observation is the fact that job burnout has been identified as a significant mechanism (Montgomery, Panagopoulou, Kehoe, & Valkanos, 2011) through which the work environment impacts on quality care. Moreover, it is possible that the need to improve quality of care may actually represent a significant stressor for HPs. Interventions to reduce burnout among HPs and consequently reduce medical errors and improve patient safety have tended to focus on structural changes. The best example of this is the recent work time directive¹ aimed at laying down minimum safety and health requirements for the organization of work time. However, evidence from 10 years later shows that it either was not adopted or had detrimental effects (especially for HPs; McIntyre, Winfield, Te, & Crook, 2010). In short, there is a significant gap in our knowledge regarding the process issues involved in delivering good quality of care.

The objective of this series is to illuminate how the context of the hospital and the well-being of the HPs (and their relationships with their patients) all coalesce to either construct or degrade quality of care. The seriousness of this topic is highlighted by the serious consequences of burnout; physicians suffering from burnout will depersonalize from their patients (Bakker, Schaufeli, Sixma, Bosveld, & Dierendonck, 2000), withdraw from their patients (Linn *et al.*, 1986), and demonstrate suboptimal care of their patients (Shanafelt, Bradley, Wipf, & Back, 2002), and in a minority of cases, burnout has even been related to serious mistakes and patient death (Firth-Cozens & Greenhalgh, 1997). Thus, the hospital is an environment in which the health of the employees is symbiotically linked with the health of the people they serve (Cox & Leiter, 1992).

¹ Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organization of working time (OJ L 299, 18 November 2003, p. 9).

Putting the hospital and quality of care in context

Hospitals are unique organizational environments where the degree to which professional roles are strongly embedded represents a significant barrier to change (Mintzberg, 1997). The Institute of Medicine (IOM) in the United States has repeatedly highlighted the link between patient safety, physician well-being, and organizational culture (Institute of Medicine, 2001; Kohn, Corrigan, & Donaldson, 1999). Put simply, HPs are under increasing pressure to continuously improve quality of care in environments that are not naturally designed to contribute positively to either the well-being of employees or the recipients of care.

Quality of care is a complex phenomenon, with multiple dimensions, sensitive to macro- and meso-social contexts, economic resources, cultural values, health professional status and norms, political support, and clients' expectations. The quality of health care can no longer be assured, and the challenges for improving it cannot be implemented based only on linear assumptions that involve a quantitative assessment of performance indicators. This process requires more sophisticated actions, beginning with the understanding of the problems and the nature of the clinical environment, health workers' motivation and commitment, patients' needs, health policy and regulatory framework, and the social context in which health services are delivered. Moreover, views on quality of care depend on one's perspective: health services providers, patients, health policy makers, and the public may all have different perceptions of what constitutes high- or poor-quality care.

This special series provides an opportunity for us to reflect on the contextual factors that surround organizational culture, quality of care, and job burnout (ORCAB) from eight countries that are participating in a European Commission Framework Seven Project (<http://orcab.web.auth.gr/>). This reflection is supported by an in-depth, qualitative methodology to understand the questions posed.

Patients and healthcare professionals: Different worldviews?

The studies reported in this special series provide an important bottom-up perspective on quality of care and the way that burnout and organizational culture are intertwined within it. Overall, the approach was a qualitative one, and the collected studies represent an in-depth examination of the experiences of 153 physicians, 133 nurses, and 46 patients across eight European countries. It is important to note that physicians are well represented in our series, which is unusual as health care organizational research is typically dominated by nurse samples.

Collectively, the studies challenge the popular IOM model of quality care: efficiency, efficacy, timeliness, patient-centredness, safety, and equitability. Both the Portuguese (Silva *et al.*, 2013) and Greek studies (Lentza, Montgomery, Georganta, & Panagopoulou, 2013) directly challenge the validity of these categories, while the Bulgarian (Todorova, Alexandrova-Karamanova, Panayotova, & Dimitrova, 2012) and Romanian (Spanu, Baban, Bria, & Dumitrascu, 2012) experiences seriously question whether the ahistorical IOM model can sufficiently capture the legacy of the past. Patient experiences, collected from Greece (Lentza *et al.*, 2013), Portugal (Silva *et al.*, 2013), and Croatia (Fazlic, Milosevic, Mustajbegovic, & Montgomery, 2013), indicate the ways in which patients are concerned with and active participants within the organization of the hospital. There is a tendency to position patients as 'end-users' or 'clients', and health department narratives emphasize these tendencies by placing importance on words such as service and delivery. Our papers

hint at the idea that this understanding is far too simplistic, and we would encourage medical organizations to view patients as active participants, even as organizational members.

All the studies in the series lean towards a job demands/job resources model of occupational stress (JD-R model, Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). However, they go far beyond it, and it is obvious that issues such as blame (Lentza *et al.*, 2013), under-appreciation (McGowan, Humphries, Burke, Conry, & Morgan, 2013), loose governance (Spanu *et al.*, 2012), justice (Todorova *et al.*, 2012), and gendered workplaces (Turk, Davas, Aksu, & Montgomery, 2013) do fit easily into demands and resources SEM variable boxes. The richness of the contextual information presented should remind us as to the dangers inherent in reifying variables. Indeed, it would be very difficult for us to understand the working conditions of the HPs without an appreciation of their context. For example, the context in Romania is the fact that leaving the system has now become a career objective (Spanu *et al.*, 2012), while in Croatia, the background concerning the Croatian Act on the Protection of Patient Rights (CAPPR) is crucial to understanding the concerns of patients and HPs (Fazlic *et al.*, 2013). In Bulgaria, health reform is intensifying hierarchies (Todorova *et al.*, 2012), while in Greece, shrinking resources promote a defensive culture that results in a blame ideology (Lentza *et al.*, 2013). The article outlining the pressures on Irish junior doctors (McGowan *et al.*, 2013) is symptomatic of the impact of austerity in the health sector, while the importance of management issues as outlined in the paper from Portugal (Silva *et al.*, 2013) is rooted in the historical movement of public hospital to corporate entities. Hospitals have stories, and these stories can drive thoughts and behaviours.

Considering the context and contextualizing some considerations

Väänänen, Anttila, Turtiainen, and Varje (2012) in a recent history of work stress recommend to researchers that there is a need to consider more information on cultural factors, social structures, and broader working life/value shifts when studying occupational health. This special series contains eight articles addressing the linkages between the hospital as a complex organization, work stress, and quality of care in different European countries, with their specific health system traditions and socio-economic environments.

Each paper makes a unique contribution to the understanding of the sources of occupational stress in the health profession and the ways in which they interfere with quality of care. The findings shed light on how institutional contexts, organizational management, and job characteristics impose constraints, not only on the capacity of health workers for better treatment decisions and choices but also on their day-to-day professional satisfaction and quality of life. The results also emphasize how problems in the system contribute to the social context of private experiences of health workers and patients. Taken as a whole, the papers make an even greater contribution, by pointing out the underlying similarities and differences across eight European countries. Despite the diversity of the countries reporting research data, it is often possible to identify an overall pattern with regard to the perceived sources of job stress: workload (administrative tasks, high number of patients, high responsibility, and decisions for treatment – often many times with the patient's life at stake), work environment (staff shortages, lack of resources), poor hospital management (lack of cooperation between departments). While some of the occupational stressors identified by the health professionals are common for all countries, others are specific only to some of them. Continuous

administrative reforms, the exclusive use of the top-down decision-making strategies, the chronic shortage of resources and supplies, and the migration of health workers have intensified the level of stress and lowered the quality of care in countries in transition, such as Bulgaria (Todorova *et al.*, 2012), Romania (Spanu *et al.*, 2012), and the former Yugoslav Republic of Macedonia (Karadzinska-Bislimovska *et al.*, 2013). The tension between the demands of work and those of the family, gender stereotypes, and discrimination against women in their careers makes female health workers more vulnerable to professional stress in Turkey (Turk *et al.*, 2013). Differences in perceptions of the sources of stress and quality of care between nurses and doctors, between healthcare providers and patients, and between male and female health workers acknowledge the complex nature of health professions, hospitals, and healthcare systems, and at the same time, they co-create them with each other. The findings show that health professionals and patients respond to the situations that create stress and risks for the quality of care by questioning the efficiency and fairness of the health policy and institutional management, by blaming the other and attributing the responsibility outside their agency, by positioning themselves as powerless victims of the system, by contesting the organizational hierarchies and injustice in hospitals, or in several different ways.

By documenting how health professionals and patients describe their experiences, feelings, attitudes, and behaviours in their everyday professional situations or in crisis situations (being ill and hospitalized), the authors provide complex representations of the phenomena studied (organizational culture, burnout, and quality of care). The experience of the stakeholders strongly suggests that the IOM model of quality care may represent health professionals in some contexts, but generally not patients. Indeed, we may need to start thinking about different models of quality of care for both patients and health professionals.

The overall message emerging from these papers is certainly more social and political with regard to health policy and health system management, which places many constraints on the occupational health of workers, on quality of care, and on patient safety and satisfaction with treatment. The papers raise a multitude of questions into which further insights are needed, such as traditional hierarchies and inequalities, power relationship and social injustice in the healthcare system, the ideology of blaming the other. Developing these insights is the key to proposing policies for a health system that is grounded in local worlds and is better able to tackle patient safety issues in hospitals and the well-being of health professionals. Furthermore, learning from the experiences and perspectives of all stakeholders (doctors, residents, nurses, patients) will enrich our theories of applied psychology related to stress, burnout, patient satisfaction, and quality of life. The social and political issues that emerge through the texts are not adequately accounted for by mainstream theories of job stress (i.e., JD-C, effort–reward imbalance, Job Demands-Resources model), and the experiences garnered from the different European countries pose interesting questions for the generalizability of these models in Balkan/South European contexts.

Reflecting on our focus group methodology

We describe our focus group methodology across so many different countries, contexts, and teams, with the aim of allowing the reader to understand our approach and in providing a template for future research. Each ORCAB team developed an ongoing relationship with one or several teaching hospitals in their countries. A common methodology for recruiting, conducting focus groups, and analysis was jointly developed and was used as a guide by all the teams, who further adjusted the methods to the specifics

of their countries and hospitals. The intention was to have three different types of focus groups conducted in each country: (1) focus groups with health professionals, discussing sources of their stress and burnout; (2) focus groups with health professionals discussing their definitions of quality of care and the dimensions of quality of care in their hospitals; and (3) focus groups with patients attending the chosen teaching hospitals, discussing how they define quality of care and their impression of quality of care in the hospitals. In some cases, the focus groups discussions were supplemented with individual interviews with health professionals. Audio recording was used in the majority of countries (7/8). The focus groups/individual interviews were conducted using a semi-structured protocol. However, the discussions were flexible, and all participants were encouraged to bring up other issues during the conversations.

The basic approach to analysis was *thematic analysis* (Braun & Clarke, 2006). Teams also choose to use other types of qualitative data analysis such as discourse analysis (Lentza et al., 2013). The key emerging themes were inductively extracted from the interviews through understanding the whole text and the connections between its parts. The interpretation included discussion of local cultural meanings, social situations, national health care situation/policy – and their relevance to findings regarding meanings of stress and quality of care.

Qualitative research methods, such as interview and focus group discussions, form a cornerstone to explore what really matters for health professionals and patients, how they construct the meaning of quality of care, their experience in providing it and receiving it, and the challenges they have to face every day. Thematic, content, and discourse analyses conducted by the authors enabled understanding the lived experiences of individual doctors, residents, nurses, and patients, within the local cultural and historical contexts. The methodology also provided insights into how personal accounts can be read as social texts, highlighting the interplay between particularization and categorization, the particular and the general.

Conclusions

The special series has illuminated the following: (1) HPs and patients understand quality of care differently; and (2) their understandings better illuminate for us how hospital environments impact negatively on the well-being of HPs, and ultimately patients.

The research uses focus groups and interviews to explore the way that HPs and patients construct meanings around quality of care. We will see that this approach elucidates multiple definitions of quality of care as a function of the perspective presented (i.e., physician, nurse, patient, spouse). At the same time, these perspectives are interlinked in a common organizational culture with shared meanings and practices. Indeed, it is not difficult to imagine how patient well-being and HPs' well-being can represent a cycle, where one negatively or positively influences the other. This special series as a whole is unique in that it presents research that asks both health professionals and patients about their meanings of burnout and quality of care, and examines these questions across eight European countries.

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