

# **Qualité de vie au travail : enjeux, perspectives, expériences**

**Anne Gervais, vice présidente CME APHP  
3 février 2016**

***Pas de lien d'intérêt en rapport avec cette présentation***

- 1. La qualité de vie au travail (QVT) ne peut pas être évaluée que par les risques psychosociaux**
- 2. Sa préservation ne peut se réduire à leur prévention**
- 3. Les soignants ont un fort investissement dans leur travail : motivation principale intrinsèque**

**La perception de la qualité de vie au travail par les professionnels dépend de leur capacité à s'exprimer et à agir sur le contenu de leur travail (HAS)**

**Qualité du travail  $\leftrightarrow$  Qualité de Vie au Travail**

with reasonable certainty what will happen to a patient, there is a single “correct” approach to treatment. Under these circumstances, it would seem to make sense for the clinician to recommend a course of action without requiring an intensive process of shared decision making.

The problem is that the benefit-risk assessments in these clinical scenarios are based on calculations that may not take into account all the patient's concerns and values. In the case of nonvalvular atrial fibrillation, for example, anticoagulation with warfarin or a new oral anticoagulant is recommended when the reduction in stroke risk exceeds the increase in bleeding risk. This calculation does not include consideration of the inconvenience of warfarin treatment or of the possibility of using aspirin, which

reduces stroke risk less than anticoagulants do but carries a lower risk of bleeding as compared with warfarin — both considerations that have been shown to influence patients' treatment preferences.<sup>3</sup>

In the case of statins for primary prevention, the recommendation is based on net absolute benefits exceeding net harms. But this calculation yields the “cor-

rect” answer only if individual patients assign the same values to the benefits and harms that the guideline authors do, and we know that patients place varying weight on both benefits and harms.<sup>4</sup>

Rather than reducing the need to involve the patient in decision making, I would argue that the availability of outcomes data makes the elicitation of patients' preferences even more important — indeed, when such data are available, it may make sense for physicians to be the most cautious about making a recommendation. When they can be given clear information about their treatment options, many patients will be able to express their priorities, and clinicians' recommendations can cause them to make choices contrary to what they would otherwise prefer.<sup>5</sup>

Thus, I believe that finding the sweet spot for shared decision making will require clinicians to work against their natural impulses to tell the patient what to do when they're certain of what's best and to leave the patient to decide when they're not. “I'm not sure what the right answer is, so why don't you decide” can be replaced with “This is a really hard decision because we aren't sure what will happen if you choose

option x; let me show you how I think about this, and you can tell me whether it fits with what's important to you.” And, equally important, “I'm recommending option x because it provides better outcomes than option y” can become “Let me tell you about the pros and cons of options x and y so that you can decide which one matches your priorities.”

Disclosure forms provided by the author are available with the full text of this article at [NEJM.org](http://NEJM.org).

From the Clinical Epidemiology Research Center, VA Connecticut Healthcare System, West Haven, and the Department of Medicine, Yale School of Medicine, New Haven — both in Connecticut.

1. McGuire AL, McCullough LB, Weller SC, Whitney SN. Missed expectations? Physicians' views of patients' participation in medical decision-making. *Med Care* 2005; 43:466-70.

2. Wolf AMD, Wender RC, Etzioni RB, et al. American Cancer Society guideline for the early detection of prostate cancer: update 2010. *CA Cancer J Clin* 2010;60:70-98.

3. Man-Son-Hing M, Gage BF, Montgomery AA, et al. Preference-based antithrombotic therapy in atrial fibrillation: implications for clinical decision making. *Med Decis Making* 2005;25:548-59.

4. Fried TR, Tinetti ME, Towle V, O'Leary JR, Iannone L. Effects of benefits and harms on older persons' willingness to take medication for primary cardiovascular prevention. *Arch Intern Med* 2011;171:923-8.

5. Gurmankin AD, Baron J, Hershey JC, Ubel PA. The role of physicians' recommendations in medical treatment decisions. *Med Decis Making* 2002;22:262-71.

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An audio interview with Dr. Fried is available at [NEJM.org](http://NEJM.org)

## Medical Taylorism

Pamela Hartzband, M.D., and Jerome Groopman, M.D.

Frederick Taylor, a son of Philadelphia aristocrats who lived at the turn of the last century, became known as the “father of scientific management” — the

original “efficiency expert.” He believed that the components of every job could and should be scientifically studied, measured, timed, and standardized to maxi-

mize efficiency and profit. Central to Taylor's system is the notion that there is one best way to do every task and that it is the manager's responsibility to ensure

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that no worker deviates from it. “In the past, the man has been first; in the future, the system must be first,” Taylor asserted.<sup>1</sup>

Toyota, inspired by these principles of “Taylorism,” successfully applied them to the manufacture of cars, thereby improving quality, eliminating waste, and cutting costs. As health care comes under increasing economic pressure to achieve these same goals, Taylorism has begun permeating the culture of medicine.

Advocates lecture clinicians about Toyota's “Lean” practices, arguing that patient care should follow standardized systems like those deployed in manufacturing automobiles. Colleagues have told us, for example, that managers with stopwatches have been placed in their clinics and emergency departments to measure the duration of patient visits. Their aim is to determine the optimal time for patient-doctor interactions so that they can be standardized.

Meanwhile, the electronic health record (EHR) — introduced with the laudable goals of making patient information readily available and improving safety by identifying dangerous drug-drug interactions — has become a key instrument for measuring the duration and standardizing the content of patient-doctor interactions in pursuit of “the one best way.” Encounters have been restructured around the demands of the EHR: specific questions must be asked, and answer boxes filled in, to demonstrate to payers the “value” of care. Open-ended interviews, vital for obtaining accurate clinical information and understanding patients' mindsets, have become almost impossible, given the limited time al-

located for visits — often only 15 to 20 minutes. Instead, patients are frequently given checklists in an effort to streamline the interaction and save precious minutes. The EHR was supposed to save time, but surveys of nurses and doctors show that it has increased the clinical workload and, more important, taken time and attention away from patients.

Physicians sense that the clock is always ticking, and patients are feeling the effect. One of our

in different languages and express individual preferences regarding when, how, and even whether they wanted to be fixed. The inescapable truth of medicine is that patients are genetically, physiologically, psychologically, and culturally diverse. It's no wonder that experts disagree about the best ways to diagnose and treat many medical conditions, including hypertension, hyperlipidemia, and cancer, among others.

To be sure, certain aspects of

*The aim of finding the one best way cannot be generalized to all of medicine, least of all to many key cognitive tasks. Good thinking takes time, and the time pressure of Taylorism creates a fertile field for cognitive errors that can result in medical mistakes.*

patients recently told us that when she came in for a yearly “wellness visit,” she had jotted down a few questions so she wouldn't forget to ask them. She was upset and frustrated when she didn't get the chance: her physician told her there was no time for her questions because a standardized list had to be addressed — she'd need to schedule a separate visit to discuss her concerns.

We believe that the standardization integral to Taylorism and the Toyota manufacturing process cannot be applied to many vital aspects of medicine. If patients were cars, we would all be used cars of different years and models, with different and often multiple problems, many of which had previously been repaired by various mechanics. Moreover, those cars would all communicate

medicine have benefited from Taylor's principles. Strict adherence to standardized protocols has reduced hospital-acquired infections, and timely care of patients with stroke or myocardial infarction has saved lives. It may be possible to find one best way in such areas. But this aim cannot be generalized to all of medicine, least of all to such cognitive tasks as eliciting an accurate history, synthesizing clinical and laboratory data to make a diagnosis, and weighing the risks and benefits of a given treatment for an individual patient. Good thinking takes time, and the time pressure of Taylorism creates a fertile field for the sorts of cognitive errors that result in medical mistakes. Moreover, rushed clinicians are likely to take actions that ignore patients' preferences.



An audio interview with Dr. Fried is available at NEJM.org

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Pamela Hartzband

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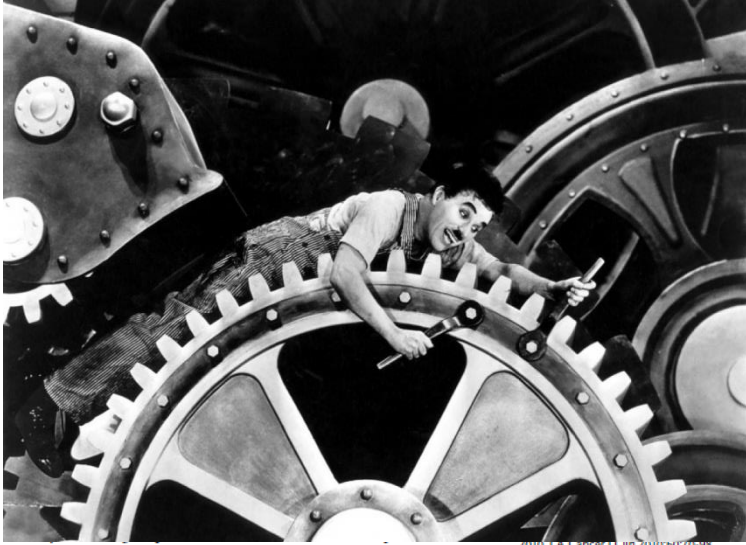
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- intensification des rythmes de travail
- déploiement d'indicateurs

\* Dr JP Devailly « kit d'ubologie clinique »



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4. Friedberg SR, et al. Shared decision making in primary prevention: a systematic review. JAMA 2016;315:100-108.

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Sentiment de dégradation de la qualité du travail et donc de la QVT



Coordinateur de parcours

Gestionnaire des portefeuilles d'activités

Qualitologue expert des qualités désirées

Synchronisateur des temps médicaux et non médicaux

Gestionnaire du capital humain efficient

Commissaire à la santé et au bien-être

Gestionnaire de risques

Gestionnaire de projet

Contrôleur de gestion

Ingénieur des soins

Technicien qualifié en qualité contrôlable

Professionnel de santé\*

- La performance n'apparaît légitime que synonyme d'amélioration de QVT
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Appareil en panne

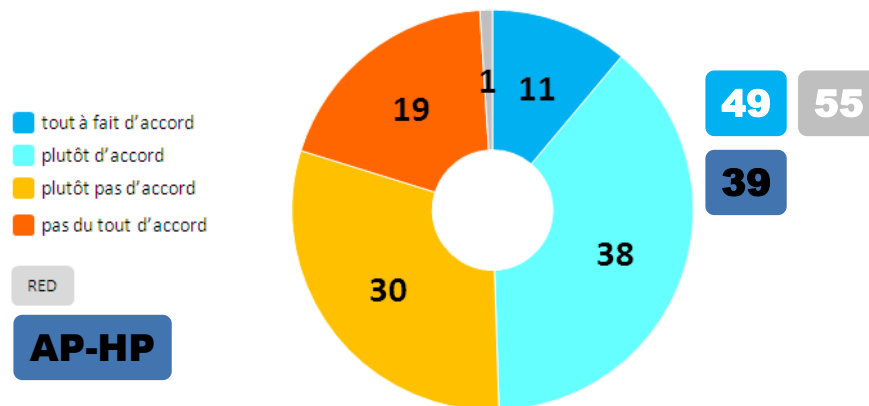
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# 86.047 PM et PNM de l'AP-HP invités à répondre du 21 mai au 24 juin 2013

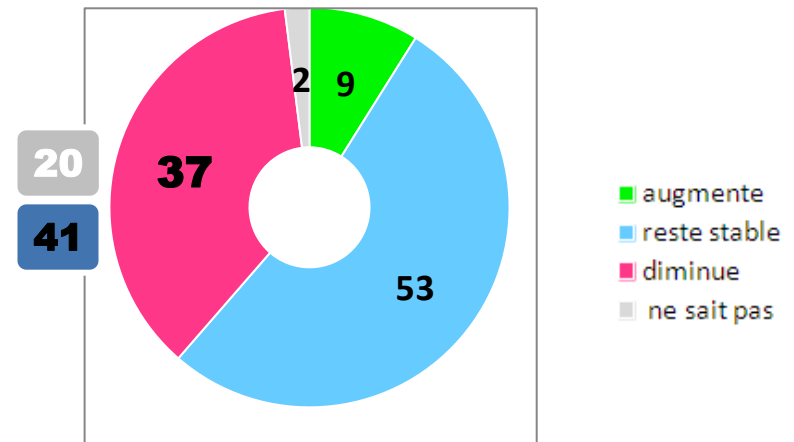
**22 100** questionnaires complétés : **Taux de participation = 26%**

**Pour le personnel médical : 2301/7492 médecins seniors invités → participation 31%**

satisfait de la reconnaissance de  
votre travail ? (%)

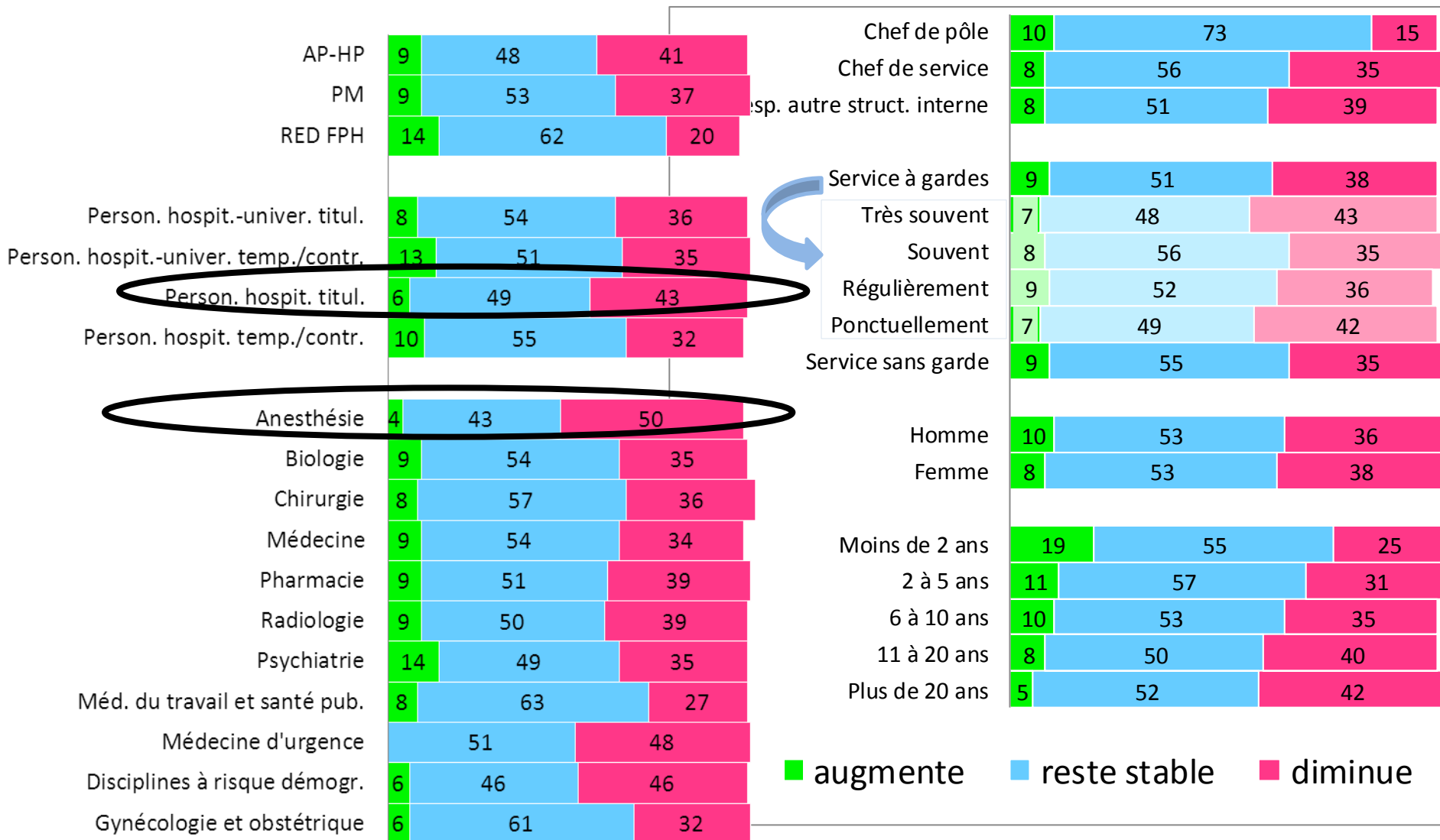


votre motivation dans  
votre travail... (%)



# MOTIVATION

Aujourd'hui, pensez-vous que votre motivation dans votre travail



# Leviers de la motivation : prise en compte des avis et propositions

Les avis ou les propositions d'amélioration faits par les professionnels sont pris en compte

	ST d'accord
AP-HP Ensemble	35
AH-HP Personnel médical	33
Personnels hospitalo-universitaires titulaires	31
Personnels hospitalo-universitaires temporaires ou contractuels	36
Personnels hospitaliers titulaires	30
Personnels hospitaliers temporaires ou contractuels	39
Anesthésie	22
Biologie	39
ST Chirurgie	26
ST Médecine	32
Pharmacie	47
ST Radiologie	24
Psychiatrie	44
ST Médecine du travail et santé publique	44
Médecine d'urgence	26
ST Disciplines à risque démographique	24
Gynécologie et obstétrique	26
Chef de pôle	66
Chef de service	41
Responsable d'une autre structure interne	32



Le débat contradictoire doit accompagner les prises de décisions. Il n'est pas naturel.

L'imposition rigide de décisions diminue la reconnaissance des compétences de ceux à qui elle s'applique.

La communication améliore la coopération : la formaliser et favoriser la communication informelle

Formation des « managers » *et des managés*, évaluation des qualités managériales.

Il faut permettre le débat sur la qualité du travail

N'inventons pas la bureaucratie de la QVT,  
ses indicateurs et ses process

**Dialogue, information, concertation dans  
les équipes, discussion sur l'organisation et  
la qualité du travail**

**\*Contre le blues**

**Du**

**R**econnaissance au travail

**A**utonomie professionnelle

**P**articipation aux décisions

# Leviers de la motivation : Filière médicale & SF

