Editorial

A recent issue of the Longwoods journal *HealthcarePapers* (www.longwoods.com/hp/5-3PatSafety/HP53index.html) stressed the importance of information technology as a mechanism to prevent medical errors. In particular the use of computerized physician order entry systems (CPOE) and clinical decision support systems (CDSS) have been advocated for preventing medication errors. However, in 2003, Kaushal, Shojania and Bates provided a systematic review of the evidence on the relationship between these types of technologies and the reduction of medication errors, (*Archives of Internal Medicine*, 163, 2003: 1409–16). Their conclusions from 12 studies are mixed. While the authors believe the use of CPOE and CDSS can substantially influence medication errors, there have been too few evaluations of the technology and their implementation. We still have a great deal to learn about how to implement change in healthcare.

Across Canada, healthcare providers and patients alike are beginning to heighten their focus on quality of services and patient safety. Medical errors and adverse events are serious concerns because of their effects on individuals and on the costs to the healthcare system. In 2004, Baker and Norton published their seminal article describing the distribution of adverse events as well as future guidelines to improve patient safety in Canadian hospitals. This report and others have contributed broadly to an increased focus on changes that need to be made to sustain and improve the safety of health services for all Canadians. This issue of *Healthcare Quarterly* examines several aspects of patient safety and current initiatives aimed at enhancing quality of care across the board.

With concerns for improving both access and quality of health services, the First Ministers created the Health Council of Canada in late 2003. Made up of 27 councillors from across Canada, the Council has the role of an impartial observer, constructively identifying issues and needs facing Canada's healthcare system, and to monitor progress in renewing Canadian healthcare. Throughout 2004, councillors studied aspects of the healthcare system, and the culmination of that work is contained in the first annual report – *Healthcare Renewal in Canada: Accelerating Change* – which was released in Ottawa on January 27, 2005.

As described by Michael Decter, the first chair of this important council, the basic message from the report is to speed up the process of change in our healthcare system. The council recognizes that there is a great deal of innovation going on across the country but results of innovation and development of new technologies are often slow to be disseminated and implemented at local levels. Decter is eminently qualified to lead such an important national endeavour – his leadership of the quality council for Cancer Care Ontario has shown much can be achieved through systematic analysis of high-priority, system-wide quality issues.

Another important national development is the creation of the Canadian Patient Safety Institute (CPSI), whose founding chair is John Wade. CPSI was announced in December 2003 by the Federal/Provincial/Territorial Ministers of Health and funded by the Government of Canada as part of its commitment of $10 million annually over five years to support national patient safety initiatives. During its first year, the founding board focused on building a foundation for the future of the organization and patient safety. This focus has been both organizational and issue-oriented and considerable effort has been made to develop the framework that will help ensure CPSI is effective and accountable. The board believes that patient safety will be – and should be – a defining issue in healthcare over the next 20 to 30 years. The Institute envisions a Canadian health system where patients, providers, governments and others work together to build and advance a safer health system; where providers take pride in their ability to deliver the safest and highest quality of care possible; and where every Canadian in need of healthcare can be confident that the care they receive is the safest in the world. The CPSI mission is to provide national leadership in building and advancing a safer Canadian health system. Philip Hassen became CEO of CPSI in December 2004 and expects to announce a call for patient safety demonstration and research proposals this year.

Still on the theme of patient safety, in this issue of *Healthcare Quarterly* we are pleased to publish an analysis of factors that might contribute to patient safety in hospitals. El-Jardali and Lagacé describe a model built on Donabedian's model of structure, process and outcome to analyze secondary data of Ontario Registered Nurse Survey of Hospital Characteristics. Results revealed that perceived under-

staffing, inadequate support services, unpleasant work environment, poor teamwork and non-supportive administration impact were important factors associated with adverse events. However, real evidence of the how to improve patient safety even in hospitals is still sparse.

On the assumption that health systems cannot meet all demands or expectations, Gibson et al. provide a synthesis of approaches from evidence-based medicine, economics and ethics as one way to help set priorities for changes in health systems.

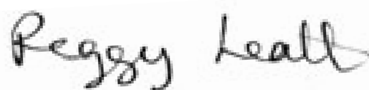
An article by Leggat and Dwyer from Australia illustrates how complex it is to bring about change in health systems. They suggest that the culture of the organization is not the answer. The authors indicate that an inappropriate culture is often presented as the reason why hospitals throughout the world have been unable to achieve best practice. Many have concluded that the organizational culture of hospitals limits the ability of these organizations to improve performance, particularly in relation to improving quality and safety. Establishment of a "better" culture is often presented as the resolution to quality, safety, financial and productivity issues in hospitals. Our research indicates that there are management prerequisites that must be present before culture change can be contemplated. Robert Smith, CEO of British Columbia's Fraser Health Authority, provides insights from his vast experience in a commentary on this article.

In a thought-provoking article, McLaughlin et al. analyze changing roles for primary-care physicians in terms of their intermediary role between advertisers and patients. Direct-to-consumer advertising is one example of a process called "disintermediation" that is having a direct effect on family physicians and their patients. This paper examines the trends and the actors involved in disintermediation which threatens the traditional patient-physician relationship. It outlines the social forces behind these threats and illustrates the resulting challenges and opportunities. A rationale and strategies are presented to rebuild, maintain and strengthen the patient-physician relationship in an era of growing disintermediation and anticipated advancements in cost-effective office-based information systems. Recognizing that this topic was likely to be controversial in the Canadian context we asked Ruth Wilson of the Department of Family Medicine at Queen's University to comment on this paper. She provides an exceptionally thoughtful analysis of this trend gaining increasing attention south of the border. We would welcome others' comments as well.

In this issue, we are also introducing a new feature – a Case Study Library that will be updated frequently online at: www.longwoods.com/CaseStudies/index.html. We have created this library to offer readers quick and easy access to best practices and innovations as they happen. The format is a click away, easy-to-use and practical – so practical that we hope that practitioners and leaders alike will use this library to advance their knowledge and understanding of emerging trends, to share successes and lessons learned and to initiate dialogue within and among teams and organizations.

We also ask you to catch up with other events across the country by reading features from CHSRF on building capacity in applied health services research; CIHR – Re-Inventing the Microscope: The Canadian Light Source (CLS); ICES – The Changing Landscape for COX-2 Inhibitors; a report from CIHI and the Quarterly Index.

As with all other issues of HQ and its growing family of publications we welcome your feedback.



Peggy Leatt, PhD