Notes from the Guest Editor

There is a great deal of truth in the ancient adage, "You can never step into the same river twice." The study of human history teaches us that change is, paradoxically, life's only constant. As someone who has spent over 30 years working in healthcare – from front-line nursing to the executive suite, and pretty much everything in between – I have been nothing short of amazed by the steady stream of, for instance, new technologies, ways of working, facilities, professions, legal issues and even illnesses.

A few years back, I heard someone refer to healthcare as a "whitewater world." How true! The River of Healthcare is a truly mighty flow, characterized by a near torrent of innovations. Yet, my experience also teaches me that there are quite a number of hard, nearly immovable and often submerged rocks and shoals over and around which our river must continually course on its way to the sea. Yes, even the biggest of boulders will erode somewhat over time; a few might even tumble a little way downstream. However, for most of the average human lifespan, these riverine obstacles will be a constant feature (on occasion, a sinking hazard) that we will encounter each time we launch our canoes into healthcare's swift currents.

The River at Fifty

Earlier this year, with the encouragement of Peggy Leatt and Dianne Foster-Kent at Longwoods, I invited Ross Graham and Shannon Sibbald to explore these fascinating waters through a retrospective consideration of the complete 1962 run of the Southam-Maclean monthly journal *Hospital Administration in Canada (HAC)*. Before it ceased publication in 1978, **HAC** (known from 1959 to July 1961 as *Hospital Construction in Canada*) was a respected go-to resource for information about topics such as healthcare policy, hospital construction and emerging medical science. Each issue, which tended to focus on hospital-related concerns, also included discussions of new technologies as well as advertisements for jobs and innovative products (e.g., stretchers, obstetrical tables and disposable surgeons' gloves).

In their thorough analysis (presented here) of all 12 issues from 1962, Graham and Sibbald discovered that 50 years ago our predecessors were facing hospital and health-system challenges and issues that, while differing in some specific details, no administrator, policy maker or care provider today would fail to recognize as ongoing concerns. As a result of their work, Graham and Sibbald were able to identify five major themes that offer "information and insight into the life and times of an *HAC* reader in 1962":

- The evolution of nursing
- Funding and legislation
- Hospital design, construction and technology
- Patient care and infection control
- Leadership

For each of these themes, the authors address the most-discussed topics presented during the year. For example, under the "evolution of nursing" theme, the issues of the day surrounded the role and value of baccalaureate-prepared nurses and male nurses, as well as how to deal with nursing shortages and wage disputes. Sound familiar?

Once Graham and Sibbald completed their work, I then set about asking a diverse, pan-Canadian crew of respected healthcare leaders to comment on our authors' findings, as well as to offer perspectives on one or more of the themes most germane to their own areas of endeavour and expertise. The results, presented in this issue of *Healthcare Papers*, offer contemporary and unique insights into what are seemingly age-old problems.

Commentaries

Following Graham and Sibbald's lead paper, we begin with an overview by Brian Postl who, among several other leadership roles, currently serves as chair of the Canadian Institute for Health Information and dean of the Faculty of Medicine at the University of Manitoba. A physician by training, Postl underscores the thematic consistency between 1962 and 2012, calling that fact "disappointing, but not surprising" (2012). For example, he points out that hospital deficits, hospital autonomy, hospital and facility design and system leadership were serious matters for debate 50 years ago and remain so today. But he also sees progress in these and other areas, including the emphasis on transparency and accountability, increased patient knowledge and empowerment and ongoing discussions about scopes of practice for nurses and other healthcare providers.

Our next commentator is Graham Scott, a distinguished Ontario lawyer with extensive experience in healthcare policy making at the provincial and federal levels, and who now serves as the chair of the board of Canada Health Infoway. In his discussion, Scott points out that, despite the passage of five decades, we still face "the fundamental issues of sustainability" as well as "serious problems with quality, safety and patient access" (2012). Concurring with Graham and Sibbald that patients were largely ignored in the "paternalistic" system of 1962, Scott argues that, despite noises to the contrary, since then "patient-centred care has advanced little." In order to make real progress on this front, we will need, he contends, to strengthen "the chain of accountability" between physicians and the chief executive officers (CEOs) and boards who administer our hospitals. Getting there, Scott says, will require educating our physicians in business organization and policy-development leadership.

In his commentary, Scott also briefly touches on the increased presence of nurses over the past 50 years in senior leadership roles. Our next two authors extend this discussion, suggesting that nurses "are leading the solutions to better health, better care and better value" in Canada's healthcare system (Smadu and Shamian 2012). Marlene Smadu, recently appointed vice-president of quality and transformation in the Regina Qu'Appelle Health Region (and former dean of nursing at the University of Saskatchewan), and Judith Shamian, the CEO of VON Canada and a former president of the Canadian Nurses Association (CNA), note that 50 years ago nurses were largely regarded as "problems to be addressed"; today, however, nurses have assumed powerful new roles closely tied to and supportive of patient-centred care. Drawing in large part on what they learned as members of the CNA's National Expert Commission on Transformation of Health and the Health System, Smadu and Shamian conclude with a compelling list of 10 topics that would, they suggest, find an ideal home in *HAC* were it to be re-launched today.

Infection control and hospital design are the twin topics in the commentary by Michael Gardam and Patti Cochrane (2012). Gardam is a physician-expert in infection control and a member of the Division of Infectious Diseases in the Faculty of Medicine, University of Toronto; and Cochrane is the vice-president of patient services and quality, and chief nurs-

ing officer, at the Trillium Health Centre, located in West Toronto and Mississauga. Zeroing in on procedure, policy and attitude shifts since 1962, Gardam and Cochrane note that interest in infection control waned after the 1960s (largely due to the effects of "the golden age of antibiotics") and has only resurfaced in a major way in the past 10 years. In this commentary, the authors describe recent advances in the re-design of patient rooms in an effort to prevent disease. They also make an important link between hospital design and "the move toward patient-centred care that began in the 1980s" (although, along with Scott, they say more needs to be done to hear and respond to "the patient voice").

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There is a natural flow (in the River of Healthcare and my own stream of consciousness) from Gardam and Cochrane's general discussion of better patient care through better design to Maura Davies's piece (2012) on Saskatchewan's new healthcare management system as it pertains to improving quality of care (which, of course, must include better infection control). Davies, the president and CEO of the Saskatoon Health Region and chair of the board of the Canadian Patient Safety Institute, positions the innovations she describes within the context of "today's consumer-driven society," a new public reality that has meant hospital boards as well as provincial and national councils must now be deeply invested in quality. In Saskatchewan's move to "patient- and family-centred care" (Davies admits more still needs to be undertaken in this regard), the province has adopted a "'made in Saskatchewan' version of the Toyota Production System" that "touches on all five dominant themes" identified by Graham and Sibbald in their review of *HAC*'s 1962 run.

From Davies's illumination of "continuous improvement" driven by patients and front-line staff alike, we move along to our two last commentaries, both of which centre on the much-debated topic of leadership, something which I have to admit has been of increasing concern to me in recent years. Drawing on his own 37-year history of healthcare leadership, Robert Smith – whose coast-to-coast career includes having held CEO positions in both British Columbia (Fraser Health Authority) and Nova Scotia (Capital District Health Authority) – highlights the major healthcare leadership styles and issues from the 1960s through the 1990s (e.g., new facilities, unionization, rapidly changing government policies and regulations, to name but a few) (Smith 2012). He then takes us inside current leadership-related challenges and approaches. There is so much in Smith's account that resonates with my own sense of what healthcare leaders require to be successful in today's world. At a more elemental, less theoretical level, Smith concludes, "thick skin and strong long-term vision are essential" for health-system leaders (attributes, I suspect, our *HAC*-reading predecessors would also have heartily endorsed).

Our final contribution comes from Mary Jo Haddad, a globally recognized health-system leader who currently serves as the president and CEO of Toronto's Hospital for Sick Children. Haddad begins from the premise that strong leadership plus stakeholder engagement "enable" the "synergy between vision, mission and values" (2012). But what are the qualities that define leadership? For Haddad, leadership is, first and foremost, "personal" –

that is to say, each person is responsible for knowing and developing his or her own leadership capacities. In the workplace, she says, one of the central tasks of leaders is "to create environments where staff have the opportunity to excel." Peering into the future of the healthcare sector as a whole, Haddad argues that leaders' main task will be to counter the three "silos of care, of funding and of social policy," a development that has led, she maintains, to a decay of "efficiency, quality and equal access." While Smith (not unlike Davies) cites Toyota's Lean approach as "the management solution of greatest benefit in today's world," Haddad encourages us also to "look beyond the technical management and leadership skills." She reasons that leaders should cultivate the "intangible" skills (such as will, wisdom, self-efficacy and integrity) that are necessary for "creating organizational cultures of caring, innovation and continuous improvement."

Complex, Adaptive, Flexible

For most Canadians, healthcare is a (perhaps the) defining characteristic of who we are as a people. As much a part of our national identity as blueberry pie, loons and the Group of Seven, it accounts for the single biggest expenditure of government dollars at the provincial/territorial and federal levels. On a more intimate level, however, it touches each and every one of us in some way over our life, and so we are all keenly interested in it. Fifty years ago, we, as a nation, embarked on an exciting new journey insofar as the provision of healthcare services was concerned. In those heady, post-war boom years, people across the country embraced an egalitarian vision of healthcare and then built a system aimed at actualizing it.

Of course, historical hindsight teaches that certain choices may not have been for the best. For example, who among us now is not made rather uncomfortable by the somewhat-paternalistic approach that surrounded so much of healthcare in the 1960s, and even in more recent years – in particular, the unquestioned authority of physicians and other clinical staff and the relegation of patients and their families to the sidelines of their own care?

Yet, among the many insights and ideas gleaned from Graham and Sibbald's lead paper and the commentaries it sparked, the following sentence stands out for me as particularly resounding: "The lesson is not that 1962 got it wrong but, rather, that we must build flexibility into our design and patient care processes in an attempt to anticipate tomorrow's needs." This short remark by Gardam and Cochrane struck me as a deeply apt tenet both for understanding and evaluating past efforts as well as for planning future innovations.

In his contribution, Smith observes that we work within a "complex adaptive system." Complex *but also* adaptive: at first blush, that seems like a paradoxical claim. However, my own experience tells me that both attributes are true and that it is, in particular, the system's *adaptive* quality that makes possible the intentional flexibility – of all kinds – required to bring about the human and organizational outcomes we desire and need.

As our system continues to evolve, what will be the role of technology? Some spectacular recent implementation failures have, I believe, had the beneficial unintended consequence of leading to broader public awareness and involvement and the realization that technological innovation must not drive but, rather, support strategic transformation. Similarly, when I look to government legislation and funding, I am hopeful that the lessons of the past have taught us that both must be clearly linked to care quality – in unadorned terms, value for customers (both patients and taxpayers).

In the past and, to a considerable extent, even now, our healthcare system was oriented principally toward care for the sick. I often

refer to it as a "sickness system" – not a healthcare system. Today, though, we are much more aware of the social determinants of health. Of course, the evidence supporting this has been around for more than 100 years, but it has taken us a while, obviously, to accept it and, more importantly, to do something about it. So, yes, we want a system that is both efficient and effective when people get sick. But we also need to address the upstream contributing factors to disease – such as income, housing, education and environment. In order to accomplish this goal, however, just as we are successfully breaking down or overcoming those sturdy silos of the past that contained and separated the various healthcare professions, organizations, institutions and sectors, so too do we need to adopt a more comprehensive, co-operative and all-encompassing approach to the management of health and disease – one that requires far greater knowledge sharing as well as legislative and funding co-operation among government ministries and healthcare providers. When, for example, will provincial ministries of health come together with ministries of education, with both groups supporting "health" funding for school feeding programs in recognition of the fact that well-fed children perform better in school and are healthier? These are the kinds of solutions-based alliances the past lacked but the future urgently needs.

In the 1960s and, to some extent, even today, the world of healthcare has been its own solitude. It is also fair to say, however, that critically important and necessary business practices (e.g., risk management, quality control/Lean, performance reporting, value-for-money audits) are more prevalent than ever before. Sound business principles and practices inform many, if not most, decisions. But business acumen without true leadership is insufficient at best and, at worst, dysfunctional.

It has been said that health-system transformation requires courage and leadership. As I look back over Canada's history, I see ample evidence of outstanding courage and leadership in individuals such as Tommy Douglas, Monique Bégin and Marc Lalonde, to name but a few. These inspiring people had the courage to make difficult, complex decisions based on their convictions, and their decisions had a significant and lasting impact on our healthcare system – and I truly believe we are all the better for it. It is exactly this sort of courage and leadership that we will require going forward if we are to ensure that we have the best healthcare system possible for Canadians, now and in the future.

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