Anyone who has been following the news recently will have been moved by the sad story of Charlie Gard, a baby in England who suffered from a rare form of mitochondrial disease (Wyatt and Siddique 2017). Charlie's final months and death raised a host of difficult – often painful – questions about medical ethics and end-of-life care. It is particularly apt, therefore, that a number of the articles in this issue of *Healthcare Quarterly* address both these issues, starting with a new ICES report that sheds light on troubling "gaps" in the provision of end-of-life care across Ontario.

Issues at End-of-Life

What do Canadians really think about end-of-life care? For example, how is enhanced pain management regarded? More controversially, what about medically assisted death? Mining data from the 2016 Health Care in Canada Survey, Terrence Montague and his co-researchers unpack levels of support and implementation priorities for a wide range of stakeholders, from physicians to the general public. To take but one example, while medically assisted death was "broadly accepted," it had "the lowest supported choice among all end-of-life care options," especially among physicians and the general public. Among other findings was the ongoing fear among "a significant professional population" over prosecution for helping someone to die, despite Ottawa's legalization of such care.

In the end-of-life arena, second medial opinions (SMOs) are increasingly viewed as vital. Sally Bean and her colleagues, however, point out the inconsistent and fragmentary approach to SMOs in critical care. Taking a "justice perspective," they argue for a "consistent policy, guideline or resource on SMOs." The three ethical principles they outline – patient welfare, resource stewardship, transparency – offer direction for policy makers shaping a "fair" evaluative process.

Ethics in Healthcare

For over 30 years, one of of the most concrete vehicles for ethics-guided healthcare has been the hospital ethics committee. Alongside these bodies, however, other "structures" have arisen. Setting out to understand the prevalence of such additional resources, Jonathan Breslin conducted a survey among Ontario hospitals. Healthcare planners will want to take note of his results, which show a marked evolution "beyond the traditional ethics committee" to include regional ethics programs, hub-and-spoke models and external ethicists.

High-Users of Healthcare

One hears a lot of talk about "high-users" of acute care. Many strategies (e.g., intensive post-discharge care transitions) to decrease such use have been tried, but none have solved the problem. By reviewing charts and surveying family doctors (FMDs) at Toronto's Sunnybrook Health Sciences Centre, Arpita Gantayet and her fellow researchers sought to "identify patient and system factors" that could be addressed. While a startling 58% of FMDs "believed that no interventions could have prevented readmissions," the authors suggest a number of initiatives, such as early palliative care referral, as potential aids.

Approaches to Alternate Level of Care

Addressing persistent high-users dovetails with efforts to bring down alternate level of care (ALC) days. Paula Chidwick and her William Osler Health System colleagues reveal that high ALC days and "patient flow gridlock" are entangled with "ethical errors," such as seeking consent for decisions when no consent is required and taking direction from a family member despite a patient's competency. The authors' six "change concepts" – including transforming our understanding of "risk tolerance" – have led Osler to achieve Ontario's lowest ALC rates.

We continue exploring this topic with Elaine Burr and Sandra Dickau's discussion of three Toronto hospitals' application of an ALC avoidance framework. "Designed to provide a roadmap of the most effective strategies to reduce the numbers of ALC patients" and how to make improvements following a "structured approach," the framework proved to be a valuable decision-making tool that was flexible enough to enable each institution to devise its own approach.

Care in the Community

Burr and Dickau touch on the "Home First" philosophy as part of ALC planning, providing a useful bridge to the next article, which looks at community paramedicine (CP) services rendered through home visits with high-use clients. Taking cost efficiency and quality-adjusted life year (QALY) as their measures, Christopher Ashton et al. analyzed a randomized controlled trial conducted among individuals with chronic conditions in Eastern Ontario. Crunching the data, they learned that, while the cost per QALY was higher than desired, "this type of CP did significantly conserve quality of life."

Patient Safety

In this issue of *Healthcare Quarterly*, you will find a CIHI report on a new hospital harm measure and CPSI's Improvement Resource. This piece coincides with an article by Roger Cheng et al. on the connection between antiepileptic drugs (AEDs) – a widely used intervention that requires individualized dosing – and "medication incidents" in Canadian hospitals. Among the authors' findings are the contributions to error of a lack

of systematic processes (e.g., for medication reconciliation) and the need for "clear and unambiguous labelling systems."

Quality Improvement

Cheng et al. break ground for our final two essays. First, Brian A. Kuzik and his co-researchers pick up where Fleming et al. (2011) left off as they recount the QI effects wrought by the reorganization and expansion of a specialist-led paediatric asthma clinic (PAC). The results vis-à-vis emergency department visits and hospital admissions were positive; however, the authors caution they are "unable to definitively establish a causal relationship" between either measure and the PAC expansion, which they, nevertheless, characterize as an "effective and sustainable strategy."

Finally, we turn to The Ottawa Hospital (TOH), a perennial hotbed of QI innovation. TOH recently adopted a Comprehensive Unit-Based Safety Program (CUSP) model for driving QI initiatives in the Division of General Surgery; the first issue tackled was surgical site infection (SSI) rates. Discussion of the model's specifics – such as a multidisciplinary "guiding coalition," informal networks and communication tactics – is illuminating, and CUSP appears to have improved SSI rates. The authors also call for those in surgery to go beyond their familiar theories and practices in order to apply "change management strategies" that have been developed in the business world. Perhaps we could extend that urging to other areas of healthcare. At the very least, it would be a fruitful area for further investigations.

– The Editors

References

Fleming, K., B. Kuzik and C. Chen. 2011. "Hospital-based Interprofessional Strategy to Reduce In-patient Admissions and Emergency Department Visits for Pediatric Asthma." *Healthcare Quarterly* 14(Special Issue 3): 47–51. doi:10.12927/hcq.2011.22577.

Wyatt, T. and H. Siddique. July 28, 2017. "Charlie Gard's Parents Say Their 'Beautiful Boy' Has Died." *The Guardian*. Retrieved August 1, 2017. <https://www.theguardian.com/uk-news/2017/jul/28/charlie-gard-dies>.