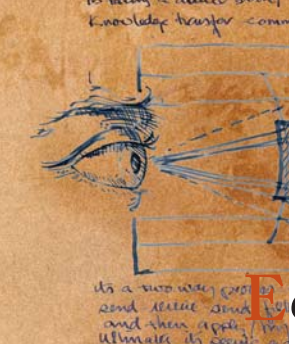


Editorial: Notes from the Editor-in-Chief

BROWMAN, SNIDER AND ELLIS must be congratulated for their outstanding efforts in beginning a discussion of managers' roles in evidence-based practice in healthcare. There is frequently a great deal of lip service paid to the importance of "the use of evidence in decision-making in health services;" such phrases appear boldly in the mission statements of the most prestigious and well-respected academic health science centres and other organizations committed to science. But translating evidence into practice seems a much more complicated matter.

Building upon Sackett et al.'s seminal definition of evidence-based medicine as "the use of the best available evidence from healthcare research in the management of individual patients," Browman et al. extend the definition to "the management of healthcare programs and systems on behalf of populations." This definition focuses on one of the key distinctions between medicine and management – medicine's unit of analysis is concerned with individual patients while managers focus on systems or populations.

Browman et al.'s main thesis is that healthcare managers are well positioned to play an active role in the research transfer process. To be effective, managers should create an environment that promotes the use of clinical evidence. Browman et al. introduce the concept of a "negotiating environment" that, in their view, facilitates a constructive partnership in which individuals share a common goal and those involved are open to compromise. The healthcare manager is able to create conditions for a successful negotiating environment by laying the groundwork for open discussion and communication. Clinicians are seen as the stewards of quality (interpreted as knowledge) and managers as the stewards of finance.

Browman et al. describe the characteristics of this type of environment through a case study from a comprehensive regional cancer centre in Ontario. In summary, what appeared to work in the case study is an environment where: 1) a clinical policy committee encourages the use of research findings; 2) champions promote the use of evidence; 3) rules define the relationships between quality (knowledge) and the finances of operations; and 4) storytelling is used as a technique to enlarge on barriers to implementation.

The authors challenge healthcare managers to document and share cases such as theirs. They present a five-point plan that suggests managers should position the use of knowledge in their organization complementary to finances, provide an appropriate decision-making structure for the use of knowledge, provide resources to measure the organization's knowledge, demonstrate leadership and share (publish) results.

The individuals providing responses to this lead paper rose magnificently to the challenges set forth by Browman et al. While they all complimented Browman et al. on their exemplary work, each reviewer was able to add substantially to the discussion. Here we begin to see the complexity of the topic and the improbability that simple solutions will lead to easy or fruitful results.

We begin first with the commentary by Lomas. Arguably, even before he assumed the position of Executive Director for the Canadian Health Services Research Foundation, Lomas was both an advocate and a champion for the transfer of health services research findings into practice in Canada. In his review, Lomas clearly points out that evidence-based decision-making is a major cultural change for any organization and as such must be accompanied by strategies that will change organizational structures and processes. Cultural change takes leadership, time and persistence. Reflecting on the context of the case study, Lomas wonders whether the use of evidence as described by Browman et al. is realistic outside the academic environment; for example, in small, rural community agencies that may not have access to the plethora of resources such as Web sites and other technologies for retrieving evidence. He also points out the rather limited role the authors ascribe to healthcare managers – one seemingly concerned primarily with finances. But more on that point later in this editorial.

Lindstrom comments on the notion of a negotiating environment. He points out that negotiation cannot and must not take the place of genuine participation and partnerships when discussing complex organizational decision-making. He suggests that a negotiation process can focus too quickly on gaining agreement without a full airing of all the various points of view and options. Dialogue, he argues, can lead to a collective intelligence that is not possible on one's own. Approaching the topic through a complex, adaptive systems model, Lindstrom stresses the importance of seeing the whole as well as its parts, and the inherent complex relationships internally and externally. He criticizes the Browman et al. paper for its simplification because it focuses on only two sets of players – clinicians and non-clinicians and on only two sets of resources – knowledge and finances.

Consumers are absent from the negotiating environment described by Browman et al. Lindstrom suggests that if we are to be true to our values – and this is a major point in the Browman article – then consumers must be part of the multi-stakeholder environment in which healthcare decisions are made. Hodnett, in her review, also emphasizes the lack of consumer perspective. It is clear that today's consumers want to be actively involved in the decisions affecting their health and their health services. With increasing frequency, consumers are demanding the evidence about the best prevention, the most effective treatment and the safest place to receive care. Perhaps it will take the forcefulness of consumers (the public) to create the rod that effectively pokes the system into evidence-based action! As Zitner rightly points out, health professionals, clinicians, managers and policy makers ignore evidence, continue to make intuitive decisions, and show no sign of remorse. And worst of all they are allowed to get away with it.

So what constitutes evidence, anyway? This is a theme that runs through all the reviews and there is certainly no consistent answer. Every Canadian commission, including the National Health Forum, provincial review bodies and the most recent ones headed by Senator Kirby and by Roy Romanow has consistently pointed out that there is a lack of information for decision-making about health services. Despite gallant efforts by the Canadian Institute for Health Information to summarize and present data in a more useable form, it seems to be a slow process getting decision-makers to actually use it.

Greater public accountability is needed. Zitner points this out in his discussion of results of international comparative research by Blendon (Health Affairs 2001) showing that Canadians have serious concerns, perhaps more so than those in other countries, about whether quality healthcare will be accessible to them in the future.

Leggat, commenting from Australia, offers a refreshing perspective by questioning our understanding of the term "evidence." Quoting from Clarke and Rollo, Leggat describes a hierarchy of meaning from raw data, through information, to knowledge and culminating, finally, in wisdom. Wisdom is described as the best use of knowledge – this appears to be the goal we are striving for but have not yet reached in evidence-based decision-making. She points out that individuals, not organizations, create knowledge and turn it into wisdom. In contrast to Browman et al., Leggat insists that organizations must consider people (not knowledge) as their highest asset.

Hodnett and others praise the authors for advocating storytelling as an appropriate methodology for the types of questions being asked in relation to research uptake. The use of stories as evidence offers an interesting paradox. On the one hand, science throughout history has been portrayed in terms of the classic scientific method and all other approaches to collecting evidence have been judged inadequate. Science is typified by disciplines such as physics, notable for its lack of contamination by the real world. Physics in its truest form is not applied knowledge. In fact, some of greatest scientists, whose work has contributed greatly to our modern world, were ignored when they were alive because their ideas were deemed too unrealistic. Medicine has mirrored the historical development of science – epitomized by basic science, clinical trials and so on. It is only recently that granting councils are providing funding for health services research. Augmenting the amount of funding for health services research has increased the acceptability of some of the social science methods such as observational studies, surveys, descriptive cases and so on. In fact, qualitative methods are now not only recognized as appropriate for the study of certain phenomenon but also are often deemed a necessary and complementary adjunct to traditional research methods.

Storytelling has part of its roots in anthropology and can add greatly to the understanding of culture. Health services researchers are borrowing heavily from anthropology to gain a better understanding of the complexities of organizational culture – this is now seen as an important managerial tool.

In examining the role of health service research in public policy making, Lavis, Ross and Hurley (2001) use the term "citable research" to refer to research that is published in a publicly available form, such as journal articles, book chapters, working papers and reports. Perhaps stories will become acceptable as citable evidence, although this will depend on the extent to which they are found acceptable in the broader arena of science.

Smith and Woods point out a number of confounding factors to the Browman et al. paper. They point out that what constitutes evidence for one person may be completely rejected as evidence by another and that this occurs regularly in practice. For example, two clinicians might disagree about the precise meaning of results of clinical research or

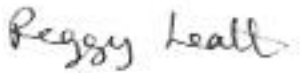
two managers might debate the correct interpretation of findings from different methods of surveying patients about their satisfaction with services. It all depends on perception – is the glass half empty or half full?

Porto, in the final commentary, takes umbrage with Browman et al.'s heavy emphasis on the limited role of the healthcare manager in relation to finances. He criticizes the paper for the very limited definition of the manager's role (a common perspective held by some physicians). Porto points out that managers, whether responsible for healthcare programs, hospitals or systems, are accountable to the public for providing leadership in its broadest sense and for carrying out a full range of management functions. Managers' roles are not just those relating to finance or evaluation. A narrow definition of management has led to many misunderstandings between clinicians and managers and this is reflected in Browman et al.'s concept of a negotiating environment in which clinicians are the stewards of knowledge and managers the stewards of finance. Porto argues that the concept of a negotiating environment exacerbates the tensions between clinicians and managers, and sets up adversarial relationships. He presents an alternative – the "expert environment."The expert environment, according to Porto, is more appropriate because it assumes the existence of collaborative relationships. He believes that management should not only be a catalyst for change but should also assume the responsibility of cultivating clinical and managerial expertise at various levels of the organization, from custodian to surgeon. He notes that experts think differently from novices and that an environment that fosters the development of expertise is not only a learning environment but also a creative problem-solving environment. In the expert environment all employees are considered knowledge stewards for their domain of activity.

All of the responding writers are clear that we need good evidence, but it is not clear what constitutes credible evidence that can be translated into practice and have an impact on how things change or happen.This seems to be the main challenge, since all the contributors to this issue agree that informed decisions are better than uninformed decisions and are the wave of the future, as demanded by consumers. A team approach appears to be the route to follow, in which clinicians, managers and consumers share the evidence and make decisions accordingly.

Snider, Ellis and Browman respond gallantly and appropriately to the seven commentaries. In true scholarly style they recognize the need for debate in the interest of improving quality of care.

I would like to take this opportunity to thank Browman, Snider and Ellis for their outstanding paper, which has contributed greatly to my personal understanding of the issues in evidence-based practice. All the commentators have added substantially to the debate and I hope this issue of Healthcare*Papers* will be read by researchers, practitioners and policy-makers in healthcare and that each will at a minimum be more informed. Perhaps it is too much to expect to have an impact as well?



Peggy Leatt
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