Crossing the boundary: changing mental models in the service of improvement

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Abstract

Assumptions constrain the vision and ability of health care systems throughout the world to achieve unprecedented levels of performance. Leaders who want to accelerate improvement should themselves question these assumptions and provide a context in which others can do so. Six current assumptions are particularly troublesome and particularly worthy of careful reconsideration: (i) that future performance levels will be approximately the same as current levels (rather than believing in the pervasive possibility of breakthrough); (ii) that measurement induces improvement (rather than emphasizing leadership of change as the key to improvement); (iii) that professional and organizational boundaries must be carefully preserved (rather than reducing those boundaries); (iv) that patients are passive and caregivers are active (rather than working from strong notions of equal partnership); (v) that traditional forms of space and equipment are well designed (rather than valuing fundamentally new designs); and (vi) that medical care operates in an environment of scarcity (rather than noticing and employing what it has in abundance).

Keywords: health care system, improvement, leadership, quality

Improvement begins with the belief that improvement is possible. The toughest, most fundamental, most frustrating barrier to improvement – the square at which we seem most often to get stuck – is the barrier we carry within: the barrier of the mind. How we think limits more than anything else what we may accomplish in improving our work. We might measure the progress of peace by noting the ease with which people and material cross boundaries. We can measure the progress of improvement by the ease with which we cross boundaries in our own minds.

Therefore, an interest in improvement leads to curiosity about these boundaries of thought, which the popular organizational theorist, Peter Senge, calls ‘mental models’ [1]. Unexamined, these deep assumptions limit our possibilities: they impede our efforts to find better ways to serve those who depend on us, and, equally important in a time of competition for social resources, they waste time and money. Leaders have both the burden and the privilege to challenge boundaries that others never think to question. In health care, six such boundaries are particularly important.

The boundary of present performance

Improvement is not an accident. It must be intended. We choose constantly between protecting the status quo (riding out the storm, getting through) and challenging the status quo (trying to become what we are not yet). In pursuing the former, we cannot discover the latter. The aim of maintenance often to get stuck ± is the barrier we carry within: the barrier and the aim of improvement are not just different aims, they contradict each other. Which aim one chooses depends what we may accomplish in improving our work. We might measure the progress of peace by noting the ease with which people and material cross boundaries. We can measure the progress of improvement by the ease with which we cross boundaries in our own minds.

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In the late 1970s, Xerox was a company in deep trouble; it was losing its market share primarily to Japanese competitors and was on the way out of business. The problem had two major causes: quality – Japanese machines broke down one-thirtieth as often as Xerox's machines; and cost – Japanese competitors were selling copiers for Xerox's unit cost of manufacturing. Xerox began a series of cost-cutting moves, including an immediate call by senior executives for a 10% cut in inventory levels. The reaction from the managers and workforce was dramatic and hostile. A 10% reduction in inventory was impossible, they claimed, or would at least involve an unacceptable level of risk. Xerox's leaders decided to visit a Japanese competitor, so that the company could establish a more realistic target. The visitors got quite a surprise; they found the competitor's inventory levels not to be 10% lower than those of Xerox, but 88% lower.

From that day forward, Xerox's whole attitude changed. They knew then that their assumptions about what was possible and necessary to achieve had been way off – off by an

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order of magnitude. The ultimate result is now manufacturing history. Within 5 or 6 years, by the mid 1980s, Xerox was producing the most reliable and the least costly copiers in the world.

That change in belief was not an accident; it was in fact an absolutely necessary step in the transformation of that company. Xerox did not begin to improve to world-class levels until its people changed their minds about what they could achieve. For pioneers in breakthrough improvement, belief in the aim does not follow achievement; belief precedes achievement.

This is a very serious problem for health care. We are an industry with extremely strong and insular traditions, especially when it comes to judgments about our performance. Many health care professionals, for example, have difficulty believing that a lesson learned in a copier company could possibly be informative for health care. Medicine is an art, the skeptics note, with far less control over its outcomes than in manufacturing. The lessons of other industries, where breakthroughs in performance are much more common, fail to penetrate the boundary of assumption about what is achievable in health care. We do not pursue breakthroughs because we do not believe, deep down, in the possibility of breakthrough.

Health care’s timidity, the failure of our aspiration, is particularly marked in one area of aim for improvement that has been the leading edge of gains for industry after industry outside health care – the reduction of waste [2]. The definition of waste, and a deep understanding of its nature, has broadened steadily in modern theories of production, and globally competitive industries have had to wage constant war against waste in order to survive. As they have done so, they have grown to understand that a high proportion of what they have been doing and producing is of no value for their customers, the people who depend on them. General Motors uses the following definition of waste in work: ‘If the customer would not willingly pay you to do it, it is waste’. Scrap is waste; inspection is waste; duplication is waste; complexity is waste; physical motion of people, material, or even information is waste. Repairing things that do not work is waste; so are inventory, waiting, and overproduction.

One particularly costly form of waste derives from failures in cooperation. When we draw boundaries too tightly, we suboptimize parts at the expense of the whole. Recently, I encountered a 21-year-old college student with cystic fibrosis, who had been admitted to the hospital for routine ‘cleanout’ care. Doing unexpectedly well on day 6 of her planned 10-day admission, she was clinically ready to go back to her dormitory on oral antibiotic therapy to complete her course of treatment. The new plan made sense, except apparently, to her health insurance plan, which ruled that it would not pay for outpatient medications. Trapped and angry, the patient, her family and her doctors reconciled themselves to an additional 4 days of inpatient treatment, at higher cost to the health plan, and a thorough waste of both the patient’s and the professionals’ time. Cooperation would have been better and cheaper.

Only when one really understands what is actually going on in the day-to-day work of an organization, and links that to deep knowledge of the real needs of customers, does one get a sound view of the true nature and extent of waste. When most modern, sophisticated organizations do look hard, they regularly discover that 50% or more of their traditional work is actually waste. In my own organization, the Institute for Healthcare Improvement, we recently examined a single internal operational process – the way we pay our bills – and we found that, by modern definitions, the waste in that process represented 92% of our effort.

A thorough exploration of the magnitude of waste in health care leads to some stunning estimates. Using an expansive and highly sophisticated definition, Professor Harry Roberts of the University of Chicago has estimated that over 90% of current health care is waste [3]. More classical studies in health services research repeatedly uncover waste in the form of unnecessary care, including 50% of cesarean sections [4], 30% of antibiotics in common infections [5] and 20% of hysterectomies [6], for example. My personal belief is that waste in health care systems in most developed countries at least surely exceeds 50% of their total resource use. For the USA, with health care costs 40% higher than the next highest nation, the figure is probably even greater.

For other dimensions of health care performance beyond cost, the gap between current performance and possible performance is just as large. Dr. Lucian Leape has shown that in good teaching hospitals, a significant medication error occurs in nearly 7% of all admissions [7]. Our service characteristics – waiting times, consistency of answering questions – would be unacceptable in most other service industries. Variation in clinical management is everywhere, and complications deriving from our work, such as operative hazards, bed sores, confusion, and loss of dignity, are pervasive when we compare the rates we can document with what the best of system designs might achieve.

We in health care need bolder aims, so that our achievements can be bolder. With firm intention, we can achieve levels of safety, service, and health status outcome that we have never yet achieved or even imagined anywhere in the current system – anywhere in the world. Furthermore, we can have those levels of quality at a cost far lower than we are now paying in the developed world. None of this is possible, of course, within the health care system as it is currently designed. But, given enough degrees of freedom in redesign, breakthroughs in performance are within our reach.

The barriers are mental. They are first and foremost barriers of belief. Only when a significant proportion of health care leaders (though it need not be a majority) begin to understand and believe in the achievability of the currently unachieved will our aspirations be high enough to begin the real process of improvement.

The boundary between measurement and action

Although our aspirations for improvement have been too low, our frustration with our current performance is high. In
the developed nations of the world, and increasingly in the
developing ones, there is a growing social insistence that
health care costs are unsupportable at current levels. In-
fuential people in many countries today think that health
care is robbing productive resources from other useful social
and commercial aims.

From this concern springs a recurrent theory of remedy:
namely, to make health care more accountable for its per-
fomance, and especially for its costs. The form of ac-
countability varies, from regulatory maneuvers like
certification, accreditation, and mandatory incident reporting,
for example, to attempts to inform the marketplace through
public reporting of scorecards, league tables, and audits, to
selective contracting within managed care systems based on
performance profiles. Behind all of this is one common
premise: if you want to improve something, measure it.
Health services researchers, system managers, governments,
consumer advocates, and many others have rallied around
the compelling idea that we cannot select, manage, or improve
what we cannot measure. It is no accident that this has been
a decade of great progress and even greater advocacy for
measuring health care's performance. It is, indeed, the pre-
vailing plan to shape up the system.

This is right in some ways; measurement can help im-
provement. But in other ways, it is also very, very wrong. To
paraphrase Joseph Juran, health care has developed a very
long leg in measurement, and a short leg in managing change,
and therefore it is walking in circles.

This is the second barrier we must overcome in our minds;
it is the high wall between our beliefs and attitudes about
measuring health care, and our capacity and will to change
it. Prof. Paul Batalden of Dartmouth Medical School has
labeled this as the gap between thinking about health care
‘from the outside in’ (as a payer or manager does in measuring
for judgment) and thinking about health care from the ‘inside
out’ (as a doctor or nurse does in trying to get through the
day under trying circumstances).

Here is the problem: measurement without change is
waste, while change without measurement is foolhardy. Yet
measuring, as we have so far tried to tackle it in health care,
has on the whole been done by outsiders who lack the
knowledge and leverage to make informed changes in the
way work is done; whereas changes in work, when ac-
complished, have been linked only rarely to modern un-
derstandings of how to measure the results of work. Although
the technologies of measurement of health status, function,
satisfaction, and cost have grown steadily through this quarter-
century, that growth has been almost entirely in the hands
of people who neither lead nor work in the system of care
itself.

I recently finished my annual duties as attending physician
on an inpatient unit of a teaching hospital, daily supervising
the work of a team of interns and residents. In my month
of service, not one of the residents engaged in a single act
of measurement of outcome that took the slightest cognisance
of the work of hundreds of health services researchers over
the past four decades. Why should they? They are not trained
to do so. Their supervisors do not do so. The measurement
of outcome, and its linkage to trials of change in care process,
is not in their job descriptions. Measurement of results, to
the extent they ever see such measurement, appears only in
the distal and hostile forms of inspection from the outside
in – completing utilization review documents, serving on
committees to prepare for the Joint Commission's triennial
visit, or perhaps getting the hospital's semiannual patient
satisfaction survey report – that they regard often as hassle,
and even more often as irrelevant to their real jobs.

Modern views of quality link measurement to action
through cycles of change. Measurement of results should be
a servant in the search for new ways of work. We should
measure primarily to learn about the actions we take, so that
we can take better actions. The prevailing mental models
keep action and measurement in separate compartments. The
judge and the worker never meet, and so long as they remain
apart we get neither reflective action nor useful measurement.

**Boundaries among professions**

Let us say we could leap over the two boundaries so far
named: the boundary between experience and possibility,
and the boundary between measurement and action. Let us
imagine that we could adopt goals that vastly exceed current
achievements, and that we could insist that the world of
assessment and the world of action become linked in cycles
of test and reflection. What then could we change as we seek
improvements?

To achieve the fullest force for improvement, we have to
put as much on the table as possible. How could you
have a wristwatch without hands? Only when you put the
underlying assumption on the table can you get a digital
watch. How can patients give themselves narcotics? Only
when the question is real, not rhetorical, could we craft
patient controlled analgesia. To repeat Einstein's advice: 'The
problems of the world cannot be solved within the boundaries
of the assumptions that created them'.

To improve dramatically, we must take the status quo off
the table. Unprecedented aims require unprecedented systems
of work. The more change we are willing to consider, the
more we may ultimately achieve. Yet, health care systems
evince tremendous resistance to examining assumptions about
the organization of work. Again, we meet mental boundaries
that constrain possibility.

One such boundary on the changes we are willing to
consider involves assumptions about professions. We happen
to have divided ourselves into doctors, nurses, technicians,
administrators, and the like. The reasons are historical, and
the categories now look wise and inevitable. They are neither
wise, nor inevitable. I am a physician. I have never, since
childhood, ever really wanted to be anything else. To this
day, when I close that door between the patient and me on
the one hand, and the rest of the world on the other, I
almost always experience a sense of privilege and refuge. I
intend to provide my patients with an opportunity that they
may find nowhere else in their lives: to share in total confi-
dence their deepest fears and questions, and to know that
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I will hear these all without judgment, without contingency, and with all of my faculties tuned to the single, focused aim of helping them. This is my purpose, my role, and my label: doctor.

Many other professionals in our system of care — nurses, technicians, managers — take equal pride in their own special role and work, and we would not want to dishonor them. But the benefits of professional pride come at a high price when we do not equally honor our interdependencies. In fact, the more we know about systems in general, the more we understand that the performance of a system — from the viewpoint of those served — depends far more crucially on how elements work together than on how each element, in its role, performs separately. The management of excellence is the management of interdependency.

Yet neither our training, nor our job descriptions, nor our language, nor our habits and rituals in day-to-day work pay sufficient attention to these connections among us. Doctors and nurses, for example, despite their crucial interdependency, do not train together or even meet together often in many systems of care. I recently suggested to a house officer under my supervision that he ask a nurse the following question: ‘What could I do to make your work easier?’ He did. The nurse answered, ‘Why? What are you up to?’ He had never asked the question before, and she had never been asked. So deep are our divisions.

We maintain the walls carefully. The hospital ward on which I teach has a Nurses’ Conference Room and a Doctors’ Conference Room. The boundaries have been carefully drawn, and well constructed. At first, they were only mental; now, there is an actual wall dividing the conference rooms. It is as if these different professions were caring for two different groups of patients.

It is time to treat the intersection of professions as powerful terrain for improvement. This goes far deeper than simply arranging for communication where it has not been nurtured before. The needed change involves not just exchange, but an actual blurring of time-honored disciplinary boundaries, the melding of professional roles and tasks into forms that do not yet exist.

When it comes to defining professions and specialties in medical care, we may have inherited definitions that are quite inappropriate for the needs of today. If there were no doctors or nurses based on history, would we invent them? Perhaps not. Dr. Larry Weed has suggested that the role of doctor as diagnostician, for example, matching enormous streams of clinical data on patients to enormous bodies of scientific literature in order to arrive at a diagnosis is the equivalent of having travel agents book flights from memory [8]. I recently sat with a resident in the hospital who was writing physician orders on the physician order form, while across the table the nurse was rewriting his orders verbatim onto the nursing care order form, while a third person was transcribing those orders onto a discharge planning sheet. ‘Why are we doing this?’ he asked. There was no answer.

Some of the most exciting changes in health care today involve questioning the boundaries of role. Dr. Robert Master in Boston has taken the idea to an informative extreme in organizing nurse practitioner teams to care for patients with severe chronic illness, such as people with spinal cord injury, end-stage neuromuscular disease, severe cerebral palsy, and quadriplegia. On those teams the traditional roles of doctors and nurses are almost completely erased. Historically, these patients got their care in academic centers from specialists — neurologists, nephrologists, orthopedists, and so on. Over 70% of all the dollars spent on their care went to hospitals, and most of the rest went to specialists. This meant, of course, that their pattern of care was not directed toward independence. They were living in medical centers. And, the care was costly. In Massachusetts, the costs were over $2200 per person per month for Medicaid, mostly for hospitals and specialists [9].

Dr. Master began to change all that in the mid 1980s working with the theory that these patients should be at home, not in hospitals, and that doctors, specialists, and hospitals should not be providing their main care. Over time, nurse practitioners began to take over the primary care doctor role: complete initial assessment, care plan, first response to all new problems (fevers, abdominal pain, etc.). They became coordinators of all care, not just classical nursing care and case management. They took first-call on nights and weekends, and restructured their role in terms, not of a 40-hour week, but of a caseload. They developed what Dr. Master calls a ‘horizontal’ relationship with backup physicians, who became involved only in the more complicated, unusual issues and specialty hospital care.

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Boundaries between patients and doctors

If the walls among professions impede our progress, those walls are only tiny fences compared with the Great Wall between doctors and patients. Upon admission to hospital, we undress the patient and assign him a special, embarrassing uniform. We remove his valuables, label his arm with his name, cook for him, change his bed covers for him. We give him pills in little paper cups, and weigh his excreta. In many
Crossing the boundary

hospitals, we limit his visitors. We forbid him from giving himself medications, even if he has been taking them at home for years. We instruct him; he does not instruct us, even when he knows more. When he complains about it, we call him unrealistic or non-compliant. In sum, we create, enforce, demand, and make normal dependency in its most aggressive form.

There is a gigantic mistake here. In fact, there are several mistakes. We are not only our patients’ hosts; we are guests in their lives. It is not our rules that should count; it is theirs. Intimidation is not our tool; it is our flaw. Let us wear the smocks with bare bottoms, listen passively to answers when no one has yet heard our questions, be confused by ancient languages, and be told we do not have common sense enough to take our own medicines, or to read and write our own records.

How often on rounds a singular doctor speaks in the first person plural, as in, ‘We are looking into your test results, Mrs. Smith, and will let you know what we find’, or, ‘We recommend surgery in such cases as yours’. This pluralization of the individual caregiver is the tip-off that someone is wearing a mask. It is the Great Wall in words. Some improvements will become possible only when ‘we’ becomes ‘I’. A family doctor, Malcolm Gourley, held my father’s hand as my father died a few years ago. No act of healing was more important then, and Dr. Gourley would never, never say, ‘We held his hand’. It was a person who touched a person, not a group that touched a group.

Some courageous doctors today are changing the rules. They are recognizing the enormous reservoir of competence that lies inside their patients, and they are experiencing a new, appropriate, and unburdening level of humility as they extend their knowledge of how much of doctoring can be taken on by the patient. They take pride in making themselves unnecessary.

Mrs. Baller phoned me. She is fully trained to treat her two severely asthmatic children at home with devices and drugs that, 5 years ago, would have been available only in an emergency room. ‘Dr. Berwick’ she said, respecting the ritual, ‘Zachary is having a little more trouble in the past few days. His peak flow rates have fallen 30 percent, and he responds less well to home nebulizer therapy. I suggest that we increase his dose of beclomethasone and initiate a short steroid pulse orally. Is that OK?’

A recent report from Finland in the British Medical Journal shows what can happen to costs and outcomes of asthma care in a controlled clinical trial when patients and families begin to manage their own conditions as Mrs. Baller can. The result of self-management: over a 50% reduction in both utilization and complication rates [10].

Dr. Larry Staker at Intermountain Health Care in Salt Lake City reviewed the control of diabetics in his patient panel, and was surprised to find a high rate of persistent hyperglycemia and poor control. His breakthrough came when he began coaching his patients to keep formal control charts of their sugar levels, and to adjust their own insulin regularly on their own. The result was unprecedented control. He has generalized this approach to self-management of hypertension, anticoagulation, and asthma care, as well [11].

Our white coats get in the way of improvement.

The boundaries of space and equipment

In the case of the two conference rooms, one for nurses and one for doctors, our mental boundaries – our boundaries of thought – have become physical. Now, the walls are real.

Before we can build improvement, we must tear some things down. Reinventing the spaces we work in may be a crucial step in developing processes with truly new capabilities. Let us take the subject of ‘space’ broadly. We should examine critically the physical world we have built, as a reflection of our current processes and assumptions, and then ask how that physical world now confines our thinking, how the servant has become the master. It was the assumption of separateness between nurses and doctors that built the wall between those conference rooms, but it may now be the wall that preserves the assumption.

On the same hospital ward as the two conference rooms, behind the unit secretary’s desk, is a pigeon-hole structure for storing paper forms. There are many forms. One for ordering a nuclear medicine scan, one for requesting blood gas analysis, one for a social service consultation, one for ordering pulmonary function tests. There is a form to accompany a specimen to the pathology lab, one to order a medical record, one to request that a key or lock be changed, and one to refer an employee to the employee health service. There is a preoperative checklist form, and a consent form for surgery. There is, of course, a form for ordering the printing and delivery of more forms. In these pigeon holes, alone, not counting other bins elsewhere in the ward, there are 78 different forms, each stocked in hundreds of copies. This architecture does not have a tongue, but it speaks. The bins say, ‘Fill me’. Only a few bins are empty. The rest are well-stocked with their respective forms, many yellowing with age. This is space designed to maintain 78 forms and more. At a deeper level, this space maintains the assumption that the forms are needed and will be used. It does not ask what is, in my mind, the crucial question: ‘Why?’ Why are there 78 forms here? What complexity, cost, hazard, and insult does this produce? Why must each test have its own special requisition? Is this, like the wall between the conference rooms, a monument to the fragmentation of our work?

The same fragmentation affects equipment of other types. On the ward in question are four different devices for measuring blood pressure all stocked for routine use on this nursing floor. They speak. They say, ‘Use me’. None asks the question, ‘Why?’ What variation in measurement comes from using four different devices, perhaps randomly, to measure the same physiologic property? One nurse becomes familiar with one device, another with another. Using their familiar machines, the night shift records different blood pressures than the day shift; or, forced to use the unfamiliar one, a nurse becomes puzzled at a pseudo-change in blood pressure that is actually only a change in equipment.
Boundaries between scarcity and abundance

I owe to my mentor, Paul Batalden, from Dartmouth Medical School, the labeling of a final confining assumption, which he calls, ‘the assumption of scarcity’ [12]. In seeking improvement, we focus much energy on noticing what we do not have enough of. We lament the lack of people, technology, and space. ‘Improving’ becomes a code word for ‘getting more’. No battle is fought more tenaciously than the battle of the budget.

We do have areas of scarcity, in developing nations especially. But, at least for the health care system in America, 40% more costly per capita than the next most costly system, it is deeply absurd to characterize the core problems of health care as problems of scarcity.

In America, as in almost all developed countries, health care already has far, far more at its disposal than, truly redesigned, it would need to achieve its social aims effectively. A student of mine asked last month why patients cannot give themselves their own medications. ‘We don’t do that here’ he was told sharply. He will not ask again.

We must rebuild our spaces and question our equipment. As our professions have boundaries that confine possibility, so do our organizations’ walls, our equipment, and our tools trap us in the beliefs that created them.

The role of leading: crossing forbidden boundaries

W. Edwards Deming said, ‘Only leaders can redraw the boundaries of the system’ [14]. These mental models that confine us do not often fall of their own weight; they are self-sustaining; they resist attack. To question them looks foolish from within. The status quo operates with an enormous sense of privilege. Can patients take care of themselves? Can we do without doctors? Can we tear down the walls? Can the lowest-level employee be trusted to guide improvement? These questions have ‘yes’ for an answer only when they are asked from outside the current system.

Most people inside our organizations cannot do that. They would risk too much. And, even if they could take such a risk, how could they know that the better answers lie in experiences they have not yet had?
It is the burden of good leadership to make the currently unthinkable thinkable, to question the obvious, to make the present systems unavailable as options for the future. The boundaries in our minds create fear about the consequences of crossing over to the undiscovered country. But the possibilities we really need do not lie on this side of our mental fences. Once crossed, those fences will look as foolish in retrospect as the beliefs of other times now often look to us.

References


