


**Exercise**

This exercise may also be accessed on this book’s companion website at ache.org/QualityManagement2.

**Objective:** To practice identifying management behaviors that express the three principles of total quality: customer focus, continuous improvement, and teamwork.

**Instructions**

1. Read the case study.
2. Describe at least one example of how management demonstrated the principle of customer focus in this case study.
3. Describe at least one example of how management demonstrated the principle of continuous improvement in this case study.
4. Describe at least one example of how management demonstrated the principle of teamwork in this case study.

**Case Study**

The following account of an improvement effort in an ambulatory surgery unit is told by the former *Wall Street Journal* columnist Thomas Petzinger, Jr.

While many companies are getting better at customer service, one industry has gotten a lot worse lately. That industry is medicine. The onslaught of managed care has commoditized what was once the most delicate relationship in all of commerce, that of doctor and patient. The practice of
“capitation” creates the risk of a doctor visit becoming a cattle call. Accounting for the payment of services has overwhelmed the rendering of the services themselves. Yet a few islands of people have thrown off their Newtonian blinders and recognized that putting the customer first can redound to the benefit of the provider as well. With so many competing claims on every dollar, every process, and every hour of time and attention, the interests of the customer—the patient—serve as a common ground for making the entire system more efficient.

One hospital is such a place: a 520-bed teaching hospital and so-called trauma-one center with a stellar clinical reputation. Within the hospital, an outpatient surgery clinic was opened long ago, in which an ever-larger percentage of procedures were being conducted. And although the surgical staff was acclaimed, management recognized that the overall patient experience left something to be desired.

The main problem was delay. The surgery line was jam-packed as early as 5:30 every morning. Some patients spent the entire day lurching from check-in to pre-op to anesthesia to surgery to recovery to post-op, with too much of the time spent simply waiting. As much as some people may wish to convalesce at length as admitted hospital patients, no one wants to turn a four-hour outpatient experience into a nine-hour ordeal. If the hospital wanted to maintain (much less extend) its position in the marketplace, it had to figure out how to get patients through faster without degrading clinical results.

The job of facilitating the planning process went to an internal quality consultant who had worked for fifteen years as a registered nurse, mostly in neonatal intensive care, before earning her MBA and fulfilling this new organizational role. In her years in intensive care, she was often perplexed by the priorities that families exhibited in even the most dire medical situations. “I’m working like crazy to save a baby, but the parents get upset because the grandparents didn’t get to see the baby!” she recalls. In time she could see that medicine was only part of health care. “Health care providers hold people’s lives in their hands at a very vulnerable time,” she says. “Health care is about a personal encounter.” Most of the people on the business side of health care have little intellectual grasp and even less emotional grasp of this concept. Indeed, after moving to the business side herself, she became convinced that some of the most intractable problems of the industry could be solved only by people who, like her, combined far-flung disciplines. “Innovation will come from people who have crossed the boundaries from other disciplines,” she says—from business to medicine, from medicine to law, and so on.

The facilitator insisted on involving the maximum number of nurses—people . . . who knew the whole patient as well as the individual surgeries they variously received. The new administrator over the area requested that the members of the improvement committee visit as many other hospitals
as possible, within their large hospital system, to explore which outpatient surgical practices could be employed at their own site. And throughout the study process, the administrator continually harped on the “vision statement” of the initiative, which put as its first priority “to provide a patient/family focused quality culture.”

This new administrator in the surgery service, a nurse herself, was a powerful force in leading the improvement effort. Under the previous leadership, the policy for change was simply “give the surgeons whatever they want,” as she put it. The administrator acknowledged that the surgeon must call the shots on procedures—but not necessarily on process. In that respect she, too, insisted on using the patient as the point of departure. “If you’re guided by only one phrase—what is best for the patient—you will always come up with the right answer,” the administrator insists. (Hearing the administrator and facilitator say this over and over began to remind me of the best editors I have worked for. When in doubt, they would often say, do only what’s right for the reader. Everything else will fall into place.)

Studying the surgery line from the patients’ point of view was disturbingly illuminating. Surgeons showing up late for the first round of surgeries at 7:30 a.m. threw off the schedule for the entire day. The various hospital departments—admitting, financing, lab, surgery—all conducted their own separate interaction with the patient on each of their individual schedules. A poor physical layout, including a long corridor separating the operating rooms from pre-op, compounded the inefficiencies. Once a patient was called to surgery, he spent forty minutes waiting for an orderly to arrive with a wheelchair or gurney. And, because this was an outpatient surgery center located inside a hospital, the anesthesiologists were accustomed to administering heavy sedation, often slowing the patient’s recovery from otherwise minor surgery and further clogging the entire line. The operation was a success, but the patient was pissed.

In talking to patients, the researchers discovered a subtext in the complaints about delays: resentment over the loss of personal control. Patients spent the day in God-awful gauze gowns, stripped of their underwear, their backsides exposed to the world. Partly this reflected a medical culture that considered the procedure, not the patient, as the customer. As the administrator put it to me, “If you’re naked on a stretcher on your back, you’re pretty subservient.” Family members, meanwhile, had to roam the hospital in search of change so they could coax a cup of coffee from a vending machine. She marveled at the arrogance of it. “You’re spending $3,000 on a loved one, but you’d better bring correct change.”

Fortunately, this administrator had the political standing to push through big changes, and although the staff surgeons effectively had veto power, most were too busy to get very deeply involved in the improvement process. Because few patients enjoy getting stuck with needles, the nurses...
created a process for capturing the blood from the insertion of each patient’s intravenous needle and sending it to the lab for whatever tests were necessary. This cut down not only on discomfort, but on time, money and scheduling complexity. The unremitting bureaucratic questions and paperwork were all replaced with a single registration packet that patients picked up in their doctors’ offices and completed days before ever setting foot in the hospital; last-minute administrative details were attended to in a single phone call the day before surgery. The nurses set up a check-in system for the coats and valuables of patients and family members, which eliminated the need for every family to encamp with their belongings in a pre-op room for the entire day. A family-friendly waiting area was created, stocked with free snacks and drinks. There would be no more desperate searches for correct change.

That was only the beginning. Patients had always resented having to purchase their post-op medications from the hospital pharmacy; simply freeing them to use their neighborhood drugstore got them out of the surgery line sooner, further relieving the congestion. Also in the interest of saving time, the nurses made a heretical proposal to allow healthy outpatients to walk into surgery under their own power, accompanied by their family members, rather than waiting forty minutes for a wheelchair or gurney. That idea got the attention of the surgeons, who after years of paying ghastly malpractice premiums vowed that the administrator, not they, would suffer the personal liability on that one. The risk-management department went “eek” at the idea. Yet as the improvement committee pointed out, the hospital permitted outpatients to traverse any other distance in the building by foot. Why should the march into surgery be any different?

In a similar vein, the nurses suggested allowing patients to wear underwear beneath their hospital gowns. The administrators could scarcely believe their ears: “Show me one place in the literature where patients wear underwear to surgery!” one top administrator demanded. (The nurses noted that restricting change to what had been attempted elsewhere would automatically eliminate the possibility of any breakthrough in performance.) And why stop at underwear, the nurses asked. The hospital was conducting more and more outpatient cataract operations; why not let these patients wear their clothes into surgery? “Contamination!” the purists cried. But clothing is no dirtier than the skin beneath it, the nurses answered. This change eliminated a major post-op bottleneck caused by elderly patients who could not dress themselves or tie their shoes with their heads clouded by anesthesia and their depth perception altered by the removal of their cataracts.

As the changes took effect, the nurses observed another unintended effect. Patients were actually reducing their recovery times! People were no longer looking at ceiling tiles on their way into surgery like characters in an episode of Dr. Kildare. They went into surgery feeling better and
came out of it feeling better. In case after case they were ready to leave the joint faster, which in turn freed up even more space for other patients. Because they had studied practices at a number of stand-alone clinics, the nurses even suggested to the physicians that the outpatients would be better off with less anesthesia, hastening their recoveries, speeding their exit, and freeing up still more capacity.

Within a year, the volume at the outpatient surgery unit had surged 50 percent with no increase in square footage and no increase in staff. Customer-service surveys were positive and costs were under control. And it dawned on the facilitator that the nurses’ intuitive conviction that the patient should come first benefited the surgery line itself at every single step. Everyone and everything connected to the process—surgeon, staff, insurers, time, cost, and quality—seemed to come out ahead when the patients’ interests came first.

What was really happening, of course, was that the change teams simply put common sense first. In a complex process of many players, the interest of the patient was the one unifying characteristic—the best baseline for calibration—because the patient was the only person touched by every step.