

## Raising Our Heads Out of the Sand

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**W**hen asked by Dr. Batalden to comment on the subject of “Lessons I Learned Leading Change in Healthcare ... and How I Learned Them” (with little other instruction), I seized upon the opportunity to reflect upon my own career path. In so doing it was important to be reminded that in reviewing another’s *curriculum vitae*, one must recognize that what looks like a logical and well-planned career path is often an illusion. What looks perfect in retrospect does not seem or feel that way in real time. In fact, Dr. Batalden’s task provided a much more accurate assessment of trajectory, forcing me to consider events and lessons learned as the punctuators of equilibrium in my professional life. To organize my thoughts around the subject, I focus on 11 punctuators or lessons and the stories behind each of them. There may be little new wisdom here and it is unlikely that these identify a sure or defined pathway to success in leading change, but they do provide a color commentary complement to the far more practical work of Kotter and others (Bohmer 2009; Kotter 1996).

### **Lesson One: Get Inspiration Wherever You Can**

We who are privileged to work in healthcare are blessed by countless sources of inspiration. These range from our patients, who persevere in the face of unthinkable tragedy,

and colleagues who give fully of themselves to talented teachers and wise, forgiving mentors. The influence of these is indelible, and much has been written about them. But there are other, more subtle influences that, in a moment of insight, have an equally profound impact on leading change. These unlikely sources of inspiration are in some ways more interesting because the impact is unpredictable and the lessons learned are often far from those originally intended.

One example of such an inspiration, which eventually led to my interest in safety as it applies to healthcare, came during the Health Professions Officer Indoctrination Course, a three-week introduction to the US Air Force for second lieutenants entered in the Air Force Health Professions Scholarship Program (which provides tuition and living expenses for medical students in return for active duty service as an Air Force medical officer at the completion of training). The course was held at Maxwell Air Force base in Montgomery, Alabama, in the August heat and humidity. On base, the air content was 21% oxygen and about 22% peanut oil from a nearby peanut butter factory, and the balance felt like water vapor. Our day consisted of morning physical training followed by some leadership classes prior to a heavy, now-recognized-to-be-bad-for-you meal. Immediately following lunch, the treat was to spend the postprandial hour in one of the few air-conditioned buildings, a lecture hall with comfortable blue seats that quickly took on the moniker of the “big blue bedroom.”

The post-lunch lectures focused on Air Force life and consisted of inspirational speakers (e.g., a former fighter pilot in Vietnam who had extensive burn wounds and who later recovered to join the astronaut corps), explanations of the chain of command and the Uniform Code of Military Justice and a few wild cards that defy classification. In the latter category, we were introduced to what was billed as an amazing treat – a video (which would now surely go viral on YouTube) demonstrating how the Air Force was addressing one of the major causes of damaged aircraft in peacetime: bird strikes. The video showed interviews with some Air Force engineers who had invented an air cannon that could actually shoot a chicken or turkey at Mach 2. The rest of the video consisted of various forms of thawed poultry being shot at the canopies of fighter jets (viewed from inside the cockpit) in slow motion set to rock music. The majority of the clips showed the bird hurling toward you, followed by a big pink splat. But every now and then the outcome was different: the canopy broke apart and the view went black – you would be dead if you were really in that cockpit.

After the video had ended, the presenter closed the session with a simple question, “Do you think this had anything to do with healthcare?” We were all confident it did not as we piled out of the lecture hall, but I could not stop thinking about the question. It took a few years for me to fully appreciate the answer, that there was something very important about studying simulated catastrophe. That unexpected lesson has been a bit

of an inspiration for me, and it made me think differently about hazard. The work of Reason (1990) and others has put this into a clearer theoretical construct, but whenever I think about simulation or go to our Center for Simulation, which is across the river by the Massachusetts Institute of Technology, I think about the “catapoultry” video.

Another source of inspiration, of course, is failures. While on active duty in the Air Force, I was lucky to share an office with a brilliant physician statistician, the late Dr. Henry Krakauer. Henry is best known for his work on the original Medicare mortality statistics (Roper et al. 1988). After his work with the Health Care Financing Administration, he turned his attention to developing quality reports for the Military Health Services System. At that time, the military health system was one of the largest socialized health systems in the world; the only larger one in terms of budget was actually that in the United Kingdom. Henry and his team, on which I was privileged to play a relatively minor role, were charged with developing a system of clinical product line quality measurement. We were able to gather exquisite data through the information and abstraction systems available in the military, and Henry did his magic with statistics producing a series of glossy reports on evidence-based best practices that, to this day, remain some of the finest quality analyses I have seen (Krakauer et al. 1998). We sent the reports to every hospital commander in the military, 128 of them worldwide, and we sat in our offices and waited. The phones didn't ring. When we began to ask military hospital leaders about what they did with the reports, we were greeted with the predictable puzzled looks – they had no idea what we were talking about.

It quickly became clear that we had developed the equivalent of a PhD-level quality report without noticing that the audience had not yet taken Healthcare Quality 101. Our efforts to use advanced statistics to define and promulgate best practices had failed miserably, but they became the inspiration for a course we designed, now called MedXcellence (<http://medxcellence.usuhs.mil/>), which takes current and future hospital leaders in the military from all three branches and exposes them to an intense, week-long, case-based learning about why and how they should look at information as a first step to improving quality. Fifteen years and nearly 1,000 students later, I continue to teach as part of that course, and maybe today those glossy reports don't end up in the garbage. Get inspiration wherever you can.

### **Lesson Two: Appreciate Honesty**

Honesty and transparency are rightly cited as two of the foundations upon which relationships in healthcare – between physicians and patients, hospitals and the public, policymakers and the electorate – are to be based. But beyond the glib statement, there must be an appreciation that sometimes honesty is difficult; it can hurt at that moment, regardless of it being the best policy in the long run. This is especially true when trying to affect change – appreciating honesty can be a very tough lesson.

This brings me to a second big blue bedroom story. One afternoon, we were informed of another “special treat,” the chief of staff of the Air Force was visiting the base that day and we were going to get a special briefing about his views of life in the Air Force. A few moments later, the general, a very elegant man in dress uniform, strode in and the audience respectfully jumped to attention (as we had been instructed). He walked to the podium, and as we sat he announced that he was here to tell us about our role in the Air Force. He then proceeded to say, “I’m going to let you know one thing – the mission of the US Air Force is to kill people and to break things. Your job is to keep us flying and fit to carry out that mission. Do you have any questions?” Hearing none, he turned around and walked out. The general’s speech matched power with brevity.

The general’s candor was brutal, to say the least; but his economy of communication was profoundly honest. He understood his mission, and he absolutely conveyed it in a way that 120 medical students from around the country could not help but understand as well. Many of us may have been on the edge of incontinence, but he got our attention and everyone quickly and quietly evaluated what the general’s message meant to them. I date my officership in the Air Force to that moment, not the comfortable commissioning ceremony of nine months earlier. Uncomfortable? Yes. Clear? Absolutely. Sometimes being blunt and being brutally honest can provide you with a great opportunity to self-reflect in a way that can positively foster change.

Another great lesson in clear communication occurred when I was at the Agency for Healthcare Research and Quality, which was then known as AHCPR. The agency director, the late Dr. John Eisenberg, and I were invited to AlCoa in Pittsburgh by Paul O’Neill, the company’s chief executive officer and later treasury secretary under George W. Bush. Although we were invited for the day, we were told to arrive the night before so that we could meet him as he walked through the door at the headquarters at 06:45. What was amazing was that this man was running the world’s largest aluminum producer with hundreds of thousands employees worldwide, and the first thing he did when he walked into his cubicle (no one there had offices; everyone had a cubicle, 81 square feet, nine by nine – a legacy from O’Neill’s days in the federal government) was to review several monitors displaying the safety reports from the day before (Arndt 2001, February 5). This was so powerful; and his honesty was that he not only talked about safety but he absolutely walked the walk, and it was highly visible to everybody around him.

The other tool I acquired from Mr. O’Neill that day was his honest approach to performance reviews. He asked only three questions, no matter what your job was. Those questions, which I still use to this day, are the following:

1. Are you treated with dignity and respect by everyone with whom you come in contact?

2. Are you given the support to do work that adds meaning to your life?
3. Does anybody notice?

That's it. Very honest, very straightforward and, for a supervisor hearing the answer, often filled with tough medicine.

Honesty is often an important catalyst for the conversion of lemons to lemonade. In December 2006, the leadership of the Massachusetts General Hospital (MGH) and the Massachusetts General Physicians Organization (MGPO) went off-site for a quality and safety retreat at the Harvard Business School. While all the chiefs, vice-presidents and some members of our board of trustees were at the retreat, our beepers went off because the Joint Commission was knocking on our door for our unannounced survey. What the Joint Commission found, a whole list of things that weren't up to either its standards or ours, was awfully sobering. When you take pride in your work and your organization, it can be truly shattering to hear criticism and recognize the truth. They were right.

We recognized that we needed to get to work on the issues the Joint Commission identified, and for that we needed to inform and engage our entire 21,000-member workforce. But that created the leadership conundrum: we needed to inform everyone, but in so doing that communication would go well beyond our own workforce. You can't control a message going out to 21,000 people. By informing our staff about what we really needed to work on, we guaranteed that the story would quickly make its way into the media. Recognizing the risk, we sent an honest and clear message that concluded, "We received a wake-up call of sorts. JCAHO surveyors had observed failures on our part to do some basic things." Predictably this less-than-flattering story was picked up by the *Boston Globe* (Kowalczyk 2007, March 17).

For all of us who were working hard to improve quality and safety, the *Globe* story was strong medicine. But it sparked a transformational embrace of honesty. Why should we rely on the media to tell our quality and safety story? With all due respect, they simply don't understand healthcare like we do. Once the honest but tough question was raised, the answer was clear – we should tell the story, openly, honestly and clearly. We put our entire 2006 Joint Commission report on the Internet (Joint Commission, 2008), included the full text of our communications with our staff, and translated those materials into a report going through each deficiency answering four questions: What did the Joint Commission find? Why is it important? What are we doing about it? Where we are now? You can go to that website today and see where we stand and constantly track our progress. Most importantly, that painful episode allowed us to get a whole lot more comfortable with transparency. That honest approach, created by an opportunity in the depth of a crisis, has made all the difference in trying to lead change in a complex organization.

### **Lesson Three: Mary Poppins Was Right**

There are a number of excellent textbooks on epidemiology from which one can learn the basics about population measurement, case-control design, rates and proportions and the importance of a *t* test. But you can actually learn many of the most important lessons from a less well-appreciated source – Mary Poppins. As a child, I can remember being mesmerized by the combination of animation and live action, vibrant colors and catchy tunes. But it was Mary Poppins’s aphorisms that had the real staying power.

Mary Poppins told us that “well begun is half done,” and for those of us trying to lead change in healthcare, there are few greater truths. One needs to have a plan, get started, constantly adapt the plan and keep the process moving. In creating the Center for Quality and Safety at the MGH and Massachusetts General Physicians Organization, we faced two choices: adapt our current organization and personnel to a new model (“old wine, new bottle”) or begin with a white board, assess what we needed and then design the organization to meet the need. The latter was more work in the beginning but was clearly the well-begun approach. The model that evolved from that effort, which explicitly links our operations with our learning, has been continually modified over the past three years. But beginning well and taking the time to think has allowed us to meet our needs in ways that a more modest restructuring could not have delivered (Bohmer et al. 2009).

Another piece of Mary Poppins wisdom was that “a spoonful of sugar helps the medicine go down.” For those of us who are trying to lead change, that spoonful of sugar, in the form of modest incentives, can be a powerful driver of spread. Incentives in healthcare are controversial because they bring in a profit motive; but when applied judiciously, one can take advantage of the fact that most of our colleagues in healthcare are not profit motivated. Applying an incentive is really not about the money – it is a statement that whatever you are incentivizing is really important. In the Joint Commission survey mentioned earlier, our hand hygiene practices were assessed, and we were still performing in the 70% range. We had a great infection control campaign that was spreading the word and providing the tools to improve, but we were not where we, or our patients, expected us to be. To help focus attention, we modified our modest operating margin incentive (which amounted to approximately \$500 for each of our 21,000 employees ) in 2007 to have half of the bonus contingent on reaching a 90% hand hygiene goal by the end of December. And you know what was really amazing? We not only met that goal, but we sustained our performance (hand hygiene rates remain in the mid-90s) after the incentive went away because we fostered the adoption of a durable habit. More importantly, our incidence of methicillin-resistant *Staphylococcus aureus* (MRSA) dropped by 70%! We have found that a similar program of modest incentives with our physicians has allowed us to avoid the dangers of de-professionalization (such as creating conflicts with specific patient care decisions, widening inequalities, demotivating an intrinsically motivating job, and distorting clinical priorities, [Berwick 1995] while helping us to promote the

adoption of important safety systems such as e-prescribing and radiology order entry, to meet important quality goals such as improving the care of patients with diabetes and pneumonia and to facilitate physician training on quality-related initiatives (Meyer et al. 2008). The modest spoonful can go a long way to promoting change.

#### **Lesson Four: Be Aware (and Beware) of History**

Historians are quick to point out that those who do not appreciate history are doomed to repeat it. The same is surely true in trying to lead change in healthcare. The fact that ignorance of history can surely undermine leading change (“Don’t you know that we tried that same thing 17 years ago and it failed miserably?”) is well appreciated. But the opposite is also true – being aware of history and, at times, embracing it can help break through barriers to change.

New issues raise uncertainty, promote dismissal as a passing fad and invite skepticism of those who believe problems are conjured up by “experts” with a personal interest in promulgating a solution. In the timeline of healthcare, patient safety and transparency feel like something new. Did patient safety begin as an issue with IOM report of 1999 (Kohn et al. 1999) or perhaps the Harvard Medical Malpractice study (Hiatt et al. 1989) of a decade earlier? Outside my office is a reprint from the *New York Times* dated November 23, 1852, titled “Fatal Mistake at the Massachusetts General Hospital.” The article goes on to describe how Dr. J.C. Warren, chief of surgery at that time and a historic figure because of his role in the introduction of ether anesthesia, encountered three patients who came in for relatively straightforward procedures but became profoundly ill after being etherized. The first two suffered temporary illness, but the third, a young man with an infection after a farming accident, died quietly immediately following the procedure with the only antecedent being a “falling pulse.” Subsequent investigation, detailed in the *Times* article, discovered that the substance that had been used was not chloric ether but chloroform. Warren had killed the patient by administering the wrong drug and told the story to the *New York Times*, which printed it in full. When people talk about transparency, patient safety and sharing our stories, the more things change, the more they remain the same – there is a certain comfort in accepting that history. Warren survived his “extreme transparency” and learned from his error. Asking our colleagues to do that now is not something new; it is merely continuing a powerful tradition.

Another colorful piece of MGH history hangs on another wall outside my office – the infamous “Back Bay Golden Goose Ostrich” cartoon drawn for Dr. Ernest Amery Codman for a presentation to the Suffolk District Medical Society in Boston in January 1915 (the original is held in the Countway Library at Harvard Medical School). Codman used the cartoon, which was inflammatory, to say the least, to promote his End Results System, which measured individual surgeons’ outcomes and proposed to share them with the public. The cartoon portrayed the fear of the MGH leadership in embracing this system that would undermine the humbugs being fed to the well-to-do of Boston

(depicted as an ostrich laying golden eggs being scooped up by the MGH faculty as its head was buried in the sand devouring the humbugs it was being fed). Codman's ideas were both prescient and way too far ahead of his time. He was eventually asked to leave the MGH, and with him went the small cards on which exquisite outcomes data were being collected. He later concluded, "Honors, except those I have thrust on myself, are conspicuously absent from my chart, but I am able to enjoy the hypothesis that I may receive some from a more receptive generation" (Mallon 1999: 195). On this too he was correct. Codman's End Results System began the medical outcomes movement in the United States and led to the creation of the Joint Commission. We should take comfort in our history as we face the challenges of leading change in healthcare. Our paths have been well trodden by those who have gone before.

### **Lesson Five: Apply Military (and Systems) Thinking**

You can fill your shelves with books about how to lead change – some of them are nonsense but many provide sound advice (one hopes that this text falls into the latter category). But if I had to have just a single reference, it would have nothing to do with healthcare. It would be an ancient military text, Sun Tzu's *The Art of War*. (There are many translations of this classic. One currently available is translated by Giles [6th century BC/2005]) (Giles, 2005). This is not because leading change in healthcare is some sort of epic battle; it is because Sun Tzu provides concise and relevant advice applicable to almost any challenge or hardship.

Whenever faced with the challenge of promoting change (which, in my world, most often involves cultures and provider behavior), I have learned to always ask a question: is this going to be a blitzkrieg or a sitzkrieg? *Blitzkrieg* means "lightning war," and *sitzkrieg* means "sitting war." Both can be effective, but matching the approach to the context is essential. There are times when we are tempted to simply say that the change is the right thing to do and we are going to forge ahead ("damn the torpedoes") and make it happen (blitzkrieg). But that does not always work out so well. In many cases, we would be far more prudent, and ultimately successful, if we adopted as our mantra the 17th century Spanish Jesuit Baltasar Gracian's "Time and I against any other two ..." or Martin Luther King's declaration, "I may be delayed, but not defeated ..." (sitzkrieg). Regardless of the approach, it is important to realize that real change hurts. Two great reminders of this come from Air Force advice: (1) if you are taking flak, you are over a high value target and (2) don't linger over the target – keep moving. If one of your goals in leading change is to make everyone happy all the time, you will quickly find yourself deadlocked and dreadfully unhappy yourself.

The military also taught me some important rules that help guide my approach to leading change, my "iron laws of improvement." The first of these is that B teams with A systems always beat A teams with B systems and absolutely crush A individuals with B systems. A prime example of this is the success of the health system of the Department

of Veterans Affairs (VA). Once plagued by front-page scandals about healthcare quality, the VA is now widely recognized as a national leader in quality and has the data to prove it (Jha et al. 2003). The VA accomplished this transformation through investing in great systems of electronic medical records, computerized order entry with decision support and investments in quality improvement systems (e.g., what now is known as NSQIP, the National Surgical Quality Improvement Program). In addition to hardware and software, the VA invested in “peopleware,” team training and other programs that knit individuals into teams. Its answer to the soccer coach’s dilemma (do I want the 11 best players or the best 11 players?) is clear – it is the team, supported by the system, that matters.

The second iron law acknowledges the pervasive, sometimes perverse and always powerful role of culture in dictating the adoption of change. It is said that Louis Pasteur told his colleagues on his deathbed that even though they had diagnosed him with a respiratory illness from which most recover, they had learned nothing from him. (Can you imagine a mentor telling you, “I’ve taught you nothing,” on his deathbed?) He told them it was “not the seed [in his case a ‘germ’ from which most recover] but the soil [an old and weary man]” that mattered most. (Sergent 1904) In leading change, we often focus on creating the perfect seed, the ideal initiative or program, with the faith that its evidentiary base and unquestionable great sense will carry the day. But the truth is that even the best seed will not take if the soil, the culture, has not been prepared. This is described as the “culture trumps all” phenomenon, and anyone who has spent time trying to lead change in healthcare can display the scars engendered by ignoring soil preparation. The technical solutions come a lot easier than the political savvy required to get them to take root. Innovation and wonderful interventions are far more exciting than safety culture surveys and working on team training, but attention to the latter is what allows those great seeds to blossom.

The third iron law recognizes that data are usually necessary but rarely sufficient to prevail in leading change. This is illustrated by a familiar scene in Washington where an earnest bureaucrat armed with statistical “evidence” is pleading with members of Congress (who are talking with colleagues, taking a snooze, typing on their BlackBerry or walking out of the room) to fund a program or project. The savviest of bureaucrats recognize that the statistics are just a prelude to the stories. The evidence has to be personalized – as soon as those data become a story about how this program will help Mrs. Smith, who is a constituent in their district, the members take heed. Data + Anecdote = Action. The same is true with physicians and nurses: data are great, but you need the story as well.

### **Lesson Six: Elizabeth Kubler-Ross Was Actually Writing about Quality Measurement, Not Death**

As mentioned earlier, change is not always pleasant. Like pain, some have higher or lower thresholds for change than others. Part of leading change is being able to help colleagues cope with the pain and move toward comfort.

This is where Elizabeth Kubler-Ross provides such a powerful lesson. Her five stages may well apply to death and dying, but there is no doubt that they also accurately describe the stages that our colleagues go through during change (Kubler-Ross 1969). The first stage is denial: “Why do we even need to do this?” “Why is this important?” With time, they move to the next step, outright anger: “I can’t believe that CMS is going to be publishing these data on us or the Leap Frog Group is really pushing us to adopt computerized order entry – don’t they have something better to do?” The next state is bargaining: “I know you can measure heart failure and diabetes care, but I really would prefer if you measured cystic fibrosis instead.” “Can’t you look at how well we do Whipple procedures on patients with pancreatic lesions?” And then you get to where most physicians and healthcare providers around America are right now with regard to change in healthcare; the reality is that their quality is going to be measured and reported publicly, and they are depressed. They’re depressed because

- A. they know public reporting is going to happen, and they are powerless to stop it – the transparency juggernaut is unstoppable;
- B. they don’t always look as good as they think they ought to, and that’s true for all of us – we all think we perform better than we actually do when examined with careful measurement; and
- C. they don’t know what to do about it, and that’s really disarming.

A key task of leading change is helping our colleagues through those stages and get them to the fifth stage, acceptance. You’re not reading this book because you like to be a B student. It’s because you want to be an A student. And when you see that you’re not an A student, it provides incredible motivation. So, the way to get people out of depression is to help them recognize the opportunity in crisis to leverage intrinsic motivation to do well, rather than to wallow in the first four stages.

### **Lesson Seven: Measure Twice, Cut Once**

When I was growing up, my father moonlighted as a carpenter, and he taught my brothers and me one of the great maxims of construction: measure twice, cut once. Care in measurement is an upfront investment in a world where we want to get to the action, to the cutting. But that investment always pays off in the long run.

A prime example of this is in the world of quality improvement in healthcare. Physicians and nurses are, by their very nature, connoisseurs of data. They have refined tastes that demand attention to every detail. With many missteps along the way, I have learned that colleagues can become comfortable with very personal and revealing quality data, but they had better be good data. The demands for high-quality data can come across as obstructionist, but that is rarely the case; more often, healthcare professionals are demonstrating that they are taking the quality measurement seriously and care about getting as close to truth as humanly possible. Skimping on the measurement, the “fast

and dirty” approach, is incredibly seductive because it offers a chance to quickly move to the action, the cutting. To guard against shortcuts, we have learned to take a step back and ask a single question: for what purpose are we measuring quality? Purposes can range from trying to generate hypotheses for an internal quality improvement program (where administrative data driven fast and dirty is a reasonable start) to demonstrating accountability to readers of the *Boston Globe* (where risk adjustment with clinical data is a must). We apply an explicit model to quality measurement to help us understand what type of data and analysis are appropriate to the stated purpose (Parkinson and Meyer 2006; Torchiana and Meyer 2005). With that defined, we then begin the task of measurement (at least twice and hopefully more to triangulate our best estimate of truth) and thereafter move to the reporting and action.

### **Lesson Eight: Hamlet Was Right as Well**

Our patients and colleagues turn to us for answers. In the ideal situation, we as leaders can provide clear guidance. But the reality is that such clarity is rare. We try to lead change in a context of ambiguity and complexity, sometimes bordering chaos. Hamlet understood that context well when he noted, “There is nothing either good or bad, but thinking makes it so.” Leading change requires as much attention to the context as it does to the answer.

An example of the mists of ambiguity in which we operate comes from pediatric cardiology. For children born with a narrowing of the outflow track from their heart, aortic valvoplasty, in which the narrowing is stretched open by a balloon catheter, provides an alternative to invasive surgery. Research has shown that the larger the balloon, the better the chance that the child will have long-term relief of symptoms. But that advantage creates risk as well because short-term complications are higher with a larger balloon. As a result, maximizing safety (by using a smaller balloon) must be balanced against maximizing effectiveness (by using a larger balloon) (Lee et al. 2007). If you’re going to measure individual cardiologists’ complication rates and publish them, by name, in the newspaper, do you think the cardiologists are going to use a small balloon or a large balloon? What’s best for the patient? Hamlet was right: there is no right answer; it is the thinking that makes it so. In leading change, we are called upon to adjudicate these ambiguities, and paying careful attention to the context makes all the difference.

### **Lesson Nine: Listen to the Signals**

Leading change can be all consuming, and it is easy to become so focused on the here and now that we lose touch with the quiet but powerful trends around us. Whether we can truly multitask is a matter of debate, but there is no doubt that leading change requires us to defy the Heisenberg uncertainty principle (that reminds us that it is impossible to measure simultaneously both position and momentum of a particle with any degree of certainty). Effective leadership requires both attention to what is in front of us (which, for those of us in healthcare, seems to come innately) and anticipation of what might be coming next.

Listening to the subtle (and increasingly not so subtle) signals in healthcare is essential to avoid being caught off guard. Healthcare today is in the midst of a gathering perfect storm where demands for improved quality, decreased costs and access for all are coming together to create a synergistic challenge for healthcare leaders. But we should hardly be surprised. The signals have been coming in, like satellite photos of merging storms, for the past decade. One can go to any major newspaper in any metropolitan area around America and see the juxtaposition of stories on the deficient state of healthcare quality and rising healthcare costs. (One example of this phenomenon can be found on the front page of the *Boston Globe* of September 19, 2003, where the lead story noted quality deficiencies at a leading hospital in Boston and the article beneath it shared the latest data on the decreased availability of employer-based health insurance.) Public perception is further shaped by emerging factoids, such as noting that not only do we spend more on healthcare for the workers that build a car than the steel and aluminum in the car, but Starbucks pays more to insure its employees than it does for coffee (Noon 2005, September 15). To those of us in healthcare, the latest technology to diagnose and treat disease is incredibly seductive. To the chief executive officers in other industries, it is compounding the healthcare-cost headache. Leading change requires us to view reality from multiple perspectives to be effective. Like the different views of the Cuban Missile Crisis captured by Graham Allison and Philip Zelikow in their recent update of the 1971 book on that stormy period, healthcare today consists of multiple concurrent realities (Allison and Zelikow, 1999). It is tempting to hunker down with our heads in the sand like Codman's ostrich and ignore those alternative views, but that won't make the signals go away. Interpreting those signals, trying to understand their meaning and anticipating change are the hard work of leadership.

### **Lesson 10: Take (Some) Chances**

The temptation to be cautious, to maintain the status quo, is overwhelming in healthcare. In healthcare reform circles, this has been captured in Altman's law, named after Brandeis University professor Stuart Altman's maxim, "If it's not my plan, I'd rather have the status quo" (Altman and Doonan 2006: 2093). But that bumps against the old military adage, "No decision is a decision and it's usually the wrong one." Taking a few chances on change, particularly during periods of calm ("fixing the roof while the sun is shining"), is essential.

It has been well known for decades that a small proportion of the population accounts for much of our healthcare spending. As a result of the emphasis on rescue care, which naturally focuses on the sickest of our patients, healthcare costs get concentrated. But there is no incentive for providers to change that situation. We are paid for what we do, not what we prevent or mitigate. Nevertheless, it is hard to argue with the prediction that improving quality and decreasing the costs of care for our sickest patients is the future of medical management. But who is going to develop those new models?

When the Center for Medicare and Medicaid Services (CMS) announced a demonstration project focused on high-cost beneficiaries, we put together a team to come up with a proposal to create that model. We took advantage of some great in-house expertise, stole shamelessly from others (with the future responsibility to give freely of what we learn) and did in-depth due diligence. In the end, we were convinced that we could make a difference for these patients. Unfortunately, we also concluded that even if we executed our plan well, we could still fall short of breaking even – in fact, \$10 million worth of falling short. That is because the institution would be at risk for the costs of the program and generating at least 5% savings for CMS. But we thought the program was important and worth taking the chance. When we presented that information to our boards, explicitly noting that we could lose up \$10 million, they gave us an unqualified green light. They shared our recognition that some chances are worth taking. To date, the program has generated those savings for CMS, we are extending it for another three years, we have improved the quality of care for our patients and we have created a program that is more popular with our primary care physicians than any other program that I have been involved with at MGH.

### **Lesson 11: Appreciate Your Mentors and Colleagues**

Perhaps the most important lessons are those we get through good fortune rather than any career development plan. Chief among those blessings is the guidance of mentors. Malcolm Gladwell wrote in 2008 about the benefits of being born at the right time (Gladwell, 2008). Just like a birthday early in the calendar year gave me a hidden advantage as a hockey player, my timing has also serendipitously provided me with all-star mentors who challenged me, gave me opportunities to fail (and learn) and steered gently.

Relationships with Joe Board, a college professor who convinced me that it was worth the chance to apply for a Rhodes scholarship; Dr. Tony Randall, a master general practitioner who provided me with the opportunity to work within the UK's National Health Service and learn how it really works; Dr. John Stoeckle, who taught me how to be a primary care physician; Dr. David Blumenthal, who introduced me to policy and threw me into the maelstrom that was Clinton healthcare reform; Dr. Henry Krakauer, who taught me the power and limitations of applying science to population health; and Dr. John Eisenberg, who provided me with the honor of working with him as he led the Agency for Healthcare, Research and Quality at an incredibly exciting time, were all gifts gained through serendipity more than masterful planning.

The one trait that they all shared, and which I have tried to emulate, is optimism. Colin Powell has said that “optimism is a force multiplier,” and my mentors mastered multiplication. In trying to lead change, it is easy to slip into the solace of cynicism; the hard work is for the optimists. My mentors also shared a gift of making those who worked with them feel good about their effort. I once witnessed John Eisenberg sum up his

career during those sad days when he was losing his battle with brain cancer. A master orator with more publications and accolades than just about anyone in medicine, John chose an unconventional but revealing path to describe his work. There were no slides of data or graphs, no references to important papers, books written or public policy crafted; it was simply a collection of pictures of the people whom he had worked with over his career. John projected the wisdom of the old saying that reflected light, like that of the moon, is far more pleasing to the eye than the direct sunlight we hope to generate. I was honored to be in one of those pictures John showed that day.

## Conclusion

Upon review, these lessons learned are an eclectic collection of experiences that, like a career, make a lot more sense in retrospect than in real time. The indulgence to reflect upon them afforded by Dr. Batalden's unusual request has been a welcome distraction from the work of leading change, or at least trying to lead change. Perhaps, in part, that distraction will actually promote the very change it hopes to describe. And if that is the case, Dr. Batalden's experiment will be a true success.

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**Gregg S. Meyer** was professionally prepared as an internist and health services researcher. We invited him to present because he has worked in national policy formulation and local change for the improvement of healthcare in complex healthcare settings.