

Diary
September 11, 1989

I arrived at Dr. D apartment^{~ NYC} (early since I was able to take an early flight to NYC) He came in at 4:30 with his driver, checked his mail then I greeted him. He gave me a big hug and said how pleased he was to see me again. He made me feel like we had known each other for years. We proceeded up to his apt. He has a very small studio apt. consisting of a kitchen, one large room that had a couch, small TV and his single bed in the corner. He was a very gracious host, showing me where things were. I wasn't quite sure what was expected of me and so I just waited for instructions. He pattered around, took off his suit coat and immediately got to the phone—getting messages and returning calls. I hung my clothes in the closet. Having finished his phone business, he asked if I would mind if he took a nap. It was dreadfully hot in the city and I'm sure he was tired after teaching class for 3 hours. He got a pillow for me and I too tried to rest. He seemed restless at first but finally his slow rhythmic breathing told me he had fallen asleep. I couldn't seem to achieve the same state given my excitement, so I decided to read.

An hour later, Dr. D seemed a little more bouncy. The air conditioning, albeit a poor, noisy one, and the nap seemed to have restored his health. He asked what I wanted for dinner. Having informed him that I eat anything, he said we would walk to a Thai restaurant- a 20minute walk. He leaned on my arm for support since the sidewalks were not very level. Once in the restaurant, we chatted about our mutual experiences in Thailand and both agreed that the people and the food were worth going back for. The restaurant was very small and there was only one other couple. Dr. D ordered a meal cooked in coconut milk and I ordered ginger Duck. As we ate, he would often look up at me and just smile. That welcoming gesture soon made my insides quiet down. The great master was after all, just a man, one who is kind and not at all concerned that no one knew or cared who he was in this little restaurant. The meal was excellent. After dinner we headed out in the cooler NY city air. I enjoyed the variety of folks we encountered. Several times we had to stop so he could catch his breath. He said he sometimes gets winded. I was worried that perhaps he was too tired to walk the 2 blocks after a tiring day, but we made it. Since he loves ice cream, after settling down he took out the ice cream from his freezer and his favorite drink, gin. We joked about the positive effect of 1 good drink each day. At 8:30, it was time for bed. I used the bathroom first, while he opened the couch and put clean sheets on my bed. He apologized for not ironing my sheets. I told him permanent press meant that was no longer needed. He then got ready for bed, and poured his gin. A full glass of ice and enough gin to fill the glass. He placed it on the table beside his bed. He made more phone calls. When he was finished I called Anita Dorf to inform her that we wouldn't be in Wichita as I had previously said, but our trip was changed to Lawrence, KS. She was very disappointed but she would try to meet us there. Dr. D said she could join us for dinner, and then we could go dancing. His dry sense of humor seems to sneak in when I least expect it.

We both settled down for the night. I found it hard to get to sleep, not believing that the figure across the room was indeed Dr. D.

Sept 12

The alarm clock woke me at 5:30 am. Dr. D was still asleep so I quietly got up and got ready. When I finally emerged, Dr. D was getting breakfast ready for me. He then asked if he could borrow my hair dryer. Not thinking (and still pretty nervous around him) I said sure. Then I realized that he had no hair!!!! He got me good. He called make-up “war paint”. I packed and made the beds. His driver was to come for us at 6:45 AM. We walked down the long corridor, down a very old elevator, and found Rudy, the driver waiting for us next to his gray Lincoln. I had never been chauffeured before, let alone by someone wearing a crisp grey uniform and matching cap. The 40-minute drive to JFK was very interesting. Rudy took us along the water front and thru the better parts of town. Not much was said. I learned to enjoy the silence with Dr. D because he is usually thinking. He does not chit chat much but does enjoy a good joke. The evening is his time for stories.

We arrived at the airport with plenty of time to spare, but by the time we got a w/c and got thru all the checkpoints, it was time to board. FIRST CLASS—what a wonderful way to travel. Once seated, the conversation centered on his work, the company leaders we would meet and various quality issues. One issue that he was particularly hot about was performance appraisals. He said we do not tell people WHY they must do things. We only tell them how and then keep them bound to a mindless job even when it doesn’t make sense to them. Worse yet, we hold them accountable. How can they do a good job if they do not understand why they do it?

I showed him a draft of an article Larry and I were working on. He liked it but offered suggestions on the statistical analysis. He asked for a copy once we were finished since he did not have many examples of improvement in healthcare. Quality Flash, the HCA Newsletter had my article about having dinner with Dr. D in Cincinnati. He read it and laughed aloud at my impressions of meeting him for the first time, how nervous I was and yet how gracious he had been to this neophyte. He asked if he could keep the article. We were served more food and drinks than I could imagine. Dr. D always checked with me to make sure I was OK.

Sometimes Dr. D would ask me questions and after I had answered, he would lean back and be quiet. All of a sudden he would come back with a comment or another question. I was soon to realize that he’d ponder what we had talked about and would seldom answer without a moment of reflection. He was always asking questions about PNG and how I dealt with trying to make changes in a culture so foreign to my own. He asked how I taught the people about illnesses. My strategy had been to tell them there were two kinds of illnesses, those caused by germs, and those caused by magic or spirits. Since they never knew which had caused the illness, I told them to come get my medicine first, and if it didn’t work, to go get some magic. I said perhaps that is the way we should approach change in our organizations. Let the old go along with the new in a way that will let the new prove superior in the long run. He needed to think about that. He leaned back, and closed his eyes, napping off and on during the flight to SFO. //

W. EDWARDS DEMING, PH.D.
CONSULTANT IN STATISTICAL STUDIES

WASHINGTON 20016
4924 BUTTERWORTH PLACE

TEL. (202) 363-8552

20 September 1987

NOTES ON MANAGEMENT IN A HOSPITAL

By me

Well here I am, flat on my back literally and in other ways, right ankle resting on three pillows. Gravity is vital to treatment.

My nurse of the moment (R.N.) came in at about 1 o'clock to wrap my leg from the knee down in a hot towel and insulator. As a first step, she turned on the hot water in the wash bowl, as she needed hot water for the towel; departed. "I'll be right back." (Some nurses use the microwave oven for this purpose.) Anyway, a social worker dropped in about a half hour later. I asked her if she would mind turning off the hot water to avoid more waste of water and energy. She did. In another half hour, the nurse came back to put on the hot towel, but she needed hot water, therefore turned on the hot water. This time she actually returned and completed the task.

Dr. Sch ordered from the drug store (in the hospital) a paste for the itch that had set in in Minneapolis. The drug store was out of one of the ingredients: must order it from the wholesaler, and can not make it up till Monday, as this is Saturday, no delivery from the wholesaler till Monday. I need it tonight. On prodding from Dr. Sch, the drug store sent someone out to another drug store to fetch the missing ingredient. The paste came up that evening.

Unbelievable: the same scenario took place some days later. My nurse of the afternoon ordered from the drug store a refill for the paste for itch. No problem, except that there would be a delay, as (again) the drug store would have to order from the wholesaler one of the ingredients. Tomorrow will be Saturday, next day Sunday; Monday they would have it. I hope to be on the way out by then. Meanwhile, they would send up a substitute, which would be in the form of a lotion, not paste. Actually, I'd prefer the lotion, but the paste came too, same evening. The drug store had again, on Dr. Sch's prodding, sent out for the missing ingredient.

On another day, my nurse of the moment (R.N.) came in three times between 0830h and 1000h to say that she would be right back to make my bed. I offered to get out of it so that she could make it up straightaway, but she may not have heard me. Each time, "I'll be right back." Anyhow, near noon she came and actually did the job. Of course, I'll live, bed made or no.

I wonder why is a registered nurse making beds? It seems to me that making beds is not good use of her time. Her education and skills could be put to better use, so it seems to me. Are there not helpers to do this kind of work? Maybe there are good reasons for what I don't understand.

All the while, nurses are on a dog-trot, panting for breath, working at top speed, losing time, not for start-up, but for no start. I know all about it; this is my way.

I was wondering about these thermometers, heavy electric cord attached. Speedy, yes, but impossible for a patient to hold correctly because of the heavy cord. The patient can only hold the thermometer against his cheek. The reading could be a whole degree low, I surmise. The aide that records temperature seemed to be totally indifferent: a reading is a reading.

The wash basin in my room has not enough space on it for a shaving mug, barely enough for a shaving brush. Bought at lowest price tag, I surmise.

The man that designed the shower had obviously never used one. The shower head, when not held by the hand, can only dangle and flood the floor. There is a tiny shelf in the shower only big enough to hold a wafer of soap. There is only one bar to hold on to. Use of this shower would be a risky business without a friend close by for rescue. Somebody sold somebody a bill of goods.

Intravenous diffusion due at 0600. The nurse came at 0505 to insert the needle into the more or less permanent spigot in my left arm, known as a Heparin Lock, departed. The infusion would run around 90 minutes. Meanwhile, some time after she left, in reaching for something on the shelf, I reached too far and pulled the needle out of the Heparin Lock. The nurse, when she came in around 0600, saw what had happened; was startled, but said not a word; merely carried everything away, liquid and tube. I supposed that she would return, and start over. Time went on; no return.

At 0830h I reported to Meg, head nurse in charge on the shift, that the intravenous diffusion due at 0600h had not been given. It was important to me, and important to Dr. D., else why bother with it? Her first impulse was to call (at home and maybe asleep) the nurse that left the job undone. It seemed to me, I told her, that it matters not what the nurse might say: I know what happened, and what did not. I called Dr. Sch. His secretary said that she would notify him at once and that he would call Dr. D.

The infusion came straightaway. The head nurse returned to say that the nurse that was to give the infusion at 0600 had recorded the infusion as given. It is possible that she recorded it in advance, with the intention to give it, and did not correct the record. Is this the regular procedure, to record intentions? Who would know?

An unsuspecting physician, looking at the record for his patient, would assume that the infusion had been given, and could draw wrong inferences about how the patient had been doing on the drug. In my case, as it turned out, no harm. But how would he know? A nurse, a physician has a right to suppose that the medication was delivered as ordered and as recorded.

Dr. Sch assured me that he is running this lapse down in every detail, and that nothing like it will ever happen again here--the usual supposition, actually only working on a defect, not on its cause.

Is it regular procedure in a hospital for a nurse to indicate on her record before she does it, that she has done it? Would she go back and change the record if she did not do it? Why should she? Who would know?

What is the purpose of the record? To inform the physician about intentions, or to tell him what happened?

A little figuring told me that insertion of the needle at 0505h, for infusion to start at 0600h (if she came back on time) would tie the patient in bed for over $2\frac{1}{2}$ hours, the first hour tied in bed, then $1\frac{1}{2}$ hours for the infusion, plus time added for the nurse to come to take the needle out of the Heparin Lock, and take the whole thing away. This long time in bed, with $\frac{3}{4}$ cup of liquid infused, could create great discomfort for a patient.

She (R.N.) would "be back in 20 minutes," to take the wrapping off the hot towel and insulation that she had just wrapped my leg in, and would apply the cream prescribed. An hour and 5 minutes later, almost time for my IV, I rang the bell to call her. She returned in 15 minutes, unwrapped my leg, and started the IV just about on time.

The food is superb. The lasagna yesterday noon was the best that I've had since the days of Iacominni's Restaurant in Akron. The baked chicken today was superb: wing attached, browned to perfection, and the sweet potato, all steaming hot. Excellent beef and barley broth. Such food in a fine restaurant would cost \$20. If only the food came on dishes here, or even on a white or light colored moulded pattern, instead of on battered brown. These trays were purchased on lowest bid, I surmise, or maybe were donated by a soup kitchen on purchase of new ones.

The Fettuccini Alfredo for dinner Monday night was the best ever, with three packets of parmesan cheese, as good as any Fettuccini Alfredo that I ever had this side of Rome. The broccoli soup was delicious. The beautiful looking apple dumpling was hot and tempting. I had already eaten enough food, but with one taste, just for trial, the dumpling was irresistible, so I finished it whether I needed it or not.

Fifteen hours elapse between dinner and breakfast. I was hungry in the middle of the night, first night; fortunately had candy bars on hand.

I have learned how to acquire and store up food like a squirrel if I get hungry during the night. I order for dinner milk as well as coffee, set the milk aside for use during the night. On hand, from friends, if needed, wonderful Scottish short bread from Scotland, Waverly crackers, candy bars. Also, I order a ripe banana for breakfast every day, put it in storage. I now have two bananas on hand, the number that I started with, but not the same bananas. FIFO, first in first out is my system.

An aide comes along around 9 o'clock to hand out juice or (I surmise) soft drinks, or milk, but I now have my own food:

The chair in this room is huge, would seat two people, takes up an exorbitant amount of space, heavy to move. Somebody had good intentions. It can be adjusted to go back as a foot-board moves into place, but need it be so big and heavy? Why not have a movable chair?

The coat hangers here are that maddening kind, found in most hotels. How I wish that I had known about them before I sent that cheque to this hospital a year ago: I should have designated \$10,000 of it to go for new racks and honest coat hangers in the rooms.

I had a new full size bar of good soap on the wash bowl. The girl that picks up trash must have thought that this kind of soap is not suited to my kind of skin. Anyway, the nurse of the moment brought to me for replacement a new bar of soap, small but appreciated.

My nurse of the moment put on a hot towel this afternoon. "I'll be back in 20 minutes, and if I don't come, please ring." Sixty-five minutes later I pressed the button. A helper came in; explained to me that this was not her kind of job, so she cancelled the light for the nurse, and went off. Thirty minutes later I rang again for the nurse. The same helper came and observed again that the job was not in her line of duty, so again she cancelled the light and went off. The solution was simple, for me, merely discard the towel and insulation myself, with the rules or against the rules. The same event recurred another day.

This experience leads to questions. Why should an aide, unable to perform the task, cancel the light? The nurse on duty for that light would not know that her patient needed a nurse. What if a nurse were suddenly vital to a patient? If he were in a single room, he would be left stranded. His nurse would not know that he had rung for her. In a room with two patients, the other one might be able to fetch a nurse. Moral, if you are acutely ill, don't go into a private room unless you have your own private nurse on duty at all times.

Shirley, a registered nurse, came to see me as a friend. She made the remark that a Heparin Lock ought to be examined at the end of 48 hours and maybe changed. It has now been in eight days. I asked later one of the nurses how long it should stay in one place. A nurse came and changed it from left arm to right arm.

What is the moral of all this? What have we learned? One answer: the Superintendent of the hospital needs to learn something about supervision. Only he can make the changes in procedure and responsibility that are required.

Talks between physicians and nurses, even with the head nurse, accomplish nothing. The same problems that I have noted will continue. A physician can not change the system. A head nurse can not change the system. Meanwhile, who would know? To work harder will not solve the problem. The nurses couldn't work any harder.

Ceil my secretary runs back and forth from here to my study only a mile away, to try to keep work moving. I have accomplished work on manuscripts due soon, and have caught up with a number of letters that have been dangling, also with some reading and re-reading in Harper's Magazine, the Atlantic Monthly, and others. It is not easy to read and to write while in bed with leg up. I violate instructions now and then, in order to write or to sign a letter, sitting up on the side of the bed, leg dangling.

I estimated, on my prescribed 4 walks per day up and down the corridor that from half to a third of the beds were unoccupied. Saturday and Sunday could have been even lower and with less bustle. Vacant beds raise the cost per patient.

D2 WEDNESDAY, SEPTEMBER 23, 1987

THE WASHINGTON POST

Poll Warns of Hospitals' Financial Deterioration

By Spencer Rich
Washington Post Staff Writer

The Healthcare Financial Management Association, which studies hospital financial trends, warned yesterday that its 1986 survey of 2,000 hospitals shows "early warning signs of financial deterioration of the hospital industry."

The organization said its survey showed profits falling from 3.6 percent of revenue in 1985 to 3 percent in 1986, the average age of plant and equipment rising from 7.2 years to 7.3 years, and a number of other indicators suggesting the financial condition in the industry "is rapidly deteriorating."

The association, which consists of about 26,000 persons involved in health-care financial management, accounting and planning, said in its study of audited reports from about 2,000 of the nation's 7,000 hospitals that "we are not predicting the immediate financial collapse of the hospital industry."

But it said that the government and other payers, which have been squeezing the industry on rates, must understand that holding increases in rates to less than the inflation rate year after year will hurt

the industry and "result in reduced access and lower quality."

The decline in profits as a percent of revenue (or operating margins, as the industry prefers to call them) is sure to generate new debate about the increase in Medicare payment rates now under consideration in Congress for fiscal 1988—1 or 2 percent, compared with an inflation rate of nearly 5 percent in the costs of things hospitals typically buy.

Government studies have suggested hospitals might have made as much as 14 percent to 15 percent on Medicare operations in 1984 and 1985, but the industry and the HFMA contend these numbers are artificial and misleading.

Ron Kovener, HFMA vice president, said, "Congress and other payers should be aware of the fact that the industry is not in fat city."

Other unfavorable numbers reported by HFMA yesterday were a decline in return on investment—from 5.2 percent in 1985 to 4.6 percent in 1986; and a decline in debt-repayment ability.

HFMA said these trends were partly counterbalanced by some favorable trends like improvement in liquidity.



The author of this article captured in a few lines the main content of my teaching.

- WED

MANAGEMENT

Wanted: Joyful Bosses

W. EDWARDS DEMING

W. Edwards Deming has been a worldwide management consultant for more than 40 years. He has authored nearly 200 papers and several books, including Out of the Crisis.

What will make for quality products and services as well as renewed leadership in the 1990s? The prime requisite for achievement of any aim, including quality, is joy in work. This will require change, and management's job is to accomplish this change.

My own estimate is that today only two in 100 people in management take joy in their work. The other 98 are under stress, not from work or overwork, but from nonproductive work—churning money, battling for or against takeover and so on. Most of the 98 have their eyes on a good rating and don't dare contribute innovation to their work.

The changes required for the 1990s will be great: they will demand a whole new philosophy requiring abolishment of annual ratings, merit systems and performance appraisals. They will require the abolishment of grades in school from toddlers on up through university.

We have been taught in North America to believe that I can win only if you lose an equal amount, and so-called business strategy is too often merely strategy to choke a competitor. This must end.

We need government agencies that take the responsibility to help the management of companies to cooperate, and not merely frighten them out of the kinds of cooperation that could help industry to compete in the world's markets.

We must, in the years ahead if we wish to survive, change to the principle of win, win. Compete, sure, but in the framework of cooperation first so everybody wins.



Helaine Messer

My last trip with Dr. Deming:

September 1993.

My assignment was to accompany him to California for a 2 day seminar. We had tickets for noon on Tuesday. Conference was Wed and Thursday and return on Friday. I was to stay with him for the weekend as I usually did, then come home on Sunday.

I arrived at National airport and was met by Dr. Deming's usual taxi driver. He had a message that I was to go to Sibley Hospital where Dr. D was a patient. (It is ironic that I was once Dir of Education at Sibley from 1980 to 1982). I arrived at the hospital and was shocked at how thin and frail he looked. I hadn't seen him in about 3 months. I told me how happy he was to see me and the usual wide smile was a little less wide. It was getting late, so I got some dinner and settled in for the night. My bed was a recliner which was not very comfortable. Every 2 hours, he would call for me to rub his back. I believe he had prostate cancer and probably had metastasis to his bones, but he never spoke of his diagnosis with me. I would rub the bony back and he'd say "dig in harder, it feels better". I would also check his pain meds to make sure he was getting it round the clock. I don't think I slept much that night.

At 8 am, Dr. D looked at the clock and said "Doris get me dressed". I frowned and asked why. He said, we have a flight at noon today. We have to be ready. I told him I didn't think he should do that, but there was no changing his mind. People were counting on him! So I found his dark suit, pockets full of cards, notes, pens, markers, etc. and helped him get dressed. Dr. Small came in at 9 and asked what was going on. I told him Dr. D was leaving to catch a plane at noon. Dr. S said he couldn't do that, he was not well enough. I told him he wasn't taking no for an answer since I had already tried. Dr. S said he would have to have Dr. D sign out AMA. Dr. D said "well, bring the papers, I have a plane to catch". So finally Dr. S said he would let him go. I asked that the hospital give me a list of meds and what needed to be done since I was going to be his nurse for the week. So then Dr. S said Dr D needed oxygen all the time, so we needed to be sure the airline could provide that. I called the airline and they said they needed 24 hours to get the proper container. When I told Dr. D, he said, well, don't tell them I need oxygen then. I told him if he passed out at 35,000 feet and his nurse with him, I would be in big trouble. "Oh, we can't have that" he said. So I hoped this was going to be the last of this trip. Not so....Dr. D called Ceil his secretary and asked that she look into getting a private jet. I then asked her to be sure they could get oxygen tanks too. I have no idea how Ceil did this so quickly but within half an hour she had a jet lined up. So the taxi took us to the private section of the airport and we boarded a small 4 seater plane. I hooked him up to the oxygen, settled in and we took off. It was a very long flight since we had to refuel twice. I kept looking at him, check his pulse and breathing. With no sleep now for 30 hours, it was a tough assignment. When we arrived in San Francisco, a limo was there to meet us. We arrived at the hotel and I was hoping he would want to nap. He said he was hungry so we went the restaurant to have his favorite food: French onion soup, ice cream and berries. Thank goodness the conference organizers had foreseen the need for another nurse for the night. I briefed the nurse, gave her the medication record and was able to finally get some sleep. The next morning at 8 am, I was back on duty. He was dressed and we had some breakfast before going to the conference room. These two day seminars were usually done with great masters like Brian Joyner, Bill Sherkenback, Peter Sholtes, Tom Nolan and many others. I understood why he wanted to do this seminar. It was the last one they were doing together. Every so often he would motion to me to help him to the bathroom. That was a little tricky since I had to go to the men's room with him. So I had one of the men check the bathroom and let anyone know that a nurse was coming in—then he'd guard the door for a few minutes. When it was time to head back home, the airline was ready with oxygen, so we didn't have to take a private jet

back. He always flew first class so it was nice to have space and comfortable seats. We arrived in Washington, DC on Friday. We had a little supper and I helped him get ready for bed. My room was close to his so I could hear him. Again, I was up every 2 hours rubbing his back and getting his pain meds. Unfortunately, there was no night nurse this time. Sunday I left at 3 PM for my flight home. He had a nurse coming after I left. I got in the cab and just cried. I knew that this was the last time I would see him. I didn't have any other trips planned after Sept and I knew this poor man would not last much longer.

December 20, 1993

As told to me: Dr. D was to go to Ford one last time before Christmas on Monday. Sunday he told Ceil he was very tired and asked that she contact Ford and asked if he could come on Tuesday instead. He died Monday morning at 3 am.

I remembered in Kansas City when a reporter asked him when he was going to retire. "Why would I want to do that? Asked Dr. D. "So you can do what you want" said the reporter. I am doing what I want was the reply. And so, he did what he wanted to do until the day he died.