

# Continuous improvement and “Continuous Improvement”

Henry A Kilham

*Change for the sake of change is not real improvement, and distracts from providing consistent high-quality care*

Who could possibly question the value of continuous improvement in any service or other collective human endeavour? It is not surprising, then, that modern management across the developed world has taken up continuous improvement as a central theme and turned it into a management strategy, which I refer to below as “Continuous Improvement<sup>MS</sup>”. Here, I wish to compare continuous improvement, as a generic entity, with the newer Continuous Improvement<sup>MS</sup>.

Continuous improvement has been around since prehistoric times. In its best form, it flowed from a particular attitude, shared by many people, ordinary and otherwise. Such people went about their work or other activities with a mind open enough to recognise better ways of doing things, or ways of doing better things, and they were prepared to try them out. Their improvements were mostly minor, but added together over time to transform tasks. These people listened to others — especially the young, who often had a fresh, new approach, and the old, who could remember changes which had not been good, and who had seen useless fashions come and go.

Occasionally, an open mind, inventiveness and serendipity would coincide to produce a spectacular advance, but the continuous improvement was generally evolutionary, not revolutionary. It took its time; it came in “fits and starts”. Old continuous improvement had the wisdom to distinguish real improvement from change for the sake of change. It valued and retained the traditional and the “tried and tested”, at least until the “new” was truly proven to be better.

I believe Continuous Improvement<sup>MS</sup>, on the other hand, is a corporate, multinational systems approach. It is a management tool, aimed at achieving specific targets and outcomes. It has become a mantra, a fundamentalist plank of modern managerialism. To me, it is a stick, not a carrot. It is like a clanking military tank set on autopilot. It assumes that improvement can be introduced by “force-feeding”. Continuous Improvement<sup>MS</sup> is supported by Strategies and Action Plans — if you don’t have these in place, then you aren’t Improving<sup>MS</sup>. Modern management believes there is no activity that cannot benefit from Continuous Improvement<sup>MS</sup>. It insists if change is not happening continuously then something is wrong.

I believe Continuous Improvement<sup>MS</sup> is particularly frustrating and disheartening when it is required to be applied to standard clinical practice, where the ongoing challenge is to maintain a high

standard, day after day, patient after patient, often with limited resources; history-taking and physical examination, for instance, don’t require continuous improvement — they just need to be done to the best standards that were taught and performed decades ago.

Continuous Improvement<sup>MS</sup> ascribes no value to the substantial achievement of maintaining a high standard, and, as far as I am aware, modern managerialism has no category to recognise it. Needing to repeatedly demonstrate compliance with Continuous Improvement<sup>MS</sup> is additionally problematic for busy clinical services, because it fails to recognise the essential, central work of such units. Continuous Improvement<sup>MS</sup>, by its very own words, implies that this essential, central work is not good enough — no wonder that it demeans hard-working, earnest people, damaging their morale.

Critics have said to me: “You just don’t understand Continuous Improvement<sup>MS</sup> and quality management generally.” But they do not seem to be aware of the extent and depth of adverse feelings to these systems approaches experienced by the people doing the work.

What of the future? Continuous Improvement<sup>MS</sup> — itself a sort of reincarnation of Total Quality Management — will disappear, only to be reincarnated as another corporatised, systematised, jargonised entity — perhaps “Non-Selective Non-Stop Upgradance (NSNSU)”)? Notwithstanding this, it would be good if modern managerialists could consider adding “Working Systems Maintenance Tracking (WSMT)” to their systems approach, if only to recognise the importance of the need to acknowledge and value good work done well, irrespective of further improvement. And clinicians will continue to dream of a system that recognises the best of what we do at the same time as questioning everything — from what people really need through to how that can be provided — then making changes with due care.

In line with current global trends, I expect reactions to what I have written will be polarised. So I will put out some challenges:

- To those who feel some empathy with what I have said — speak up! Express your concerns, and make suggestions for some real continuous improvement in quality and other management.
- To those who object to what I have written — pilot and perfect new management strategies on a small scale to show they have the potential to produce substantial, real benefits for real people. Only then, “roll them out”. Additionally, accept the same standards of evidence and accountability that you demand of others.

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