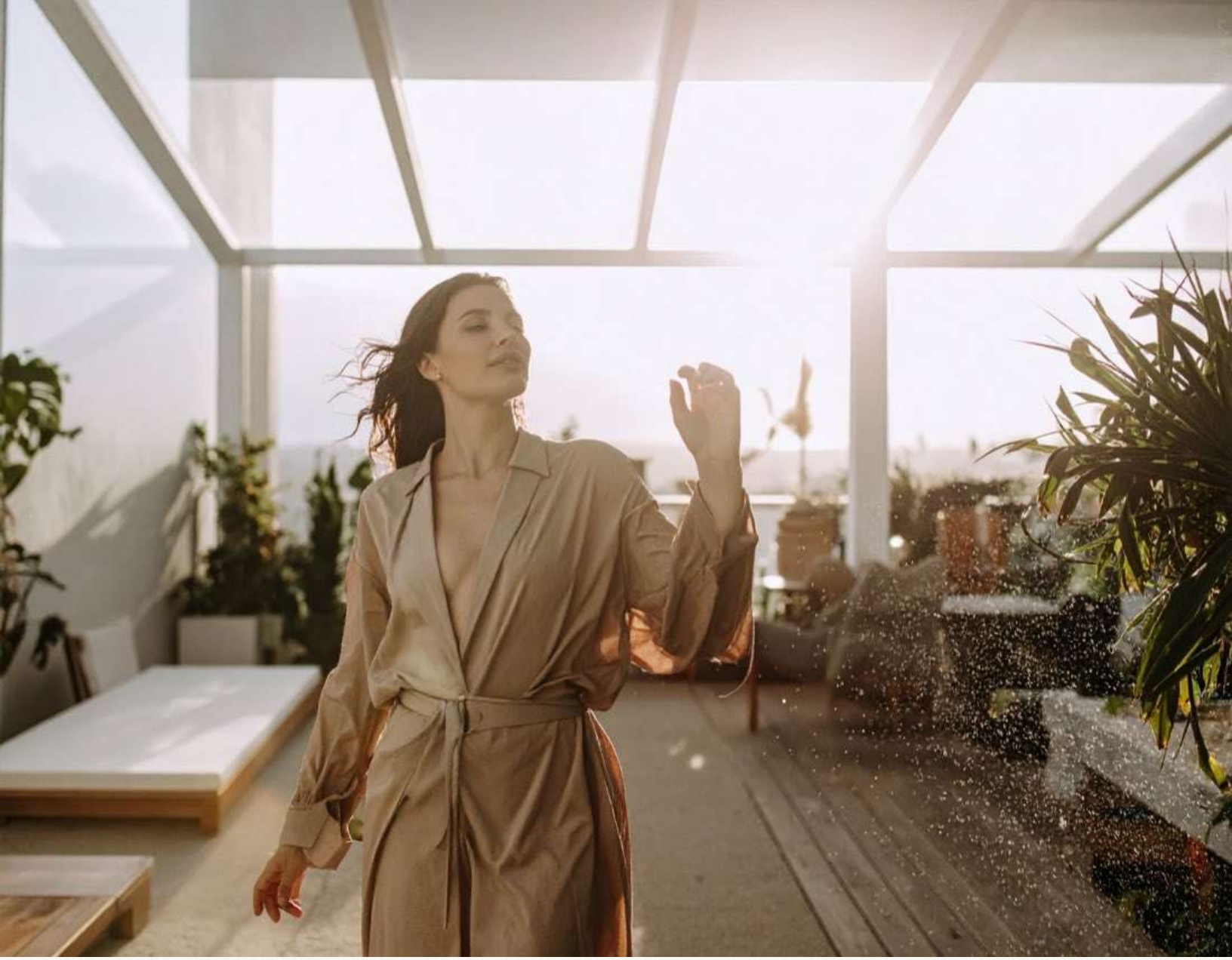


WHERE THE FLOW STOPS · CHAPTER FOUR

The Person Who Already Knows

The nurse who fetches linen from another unit has solved the problem for her patients, and nobody who could stop it happening has been told.

Ammanuel Santa Anna

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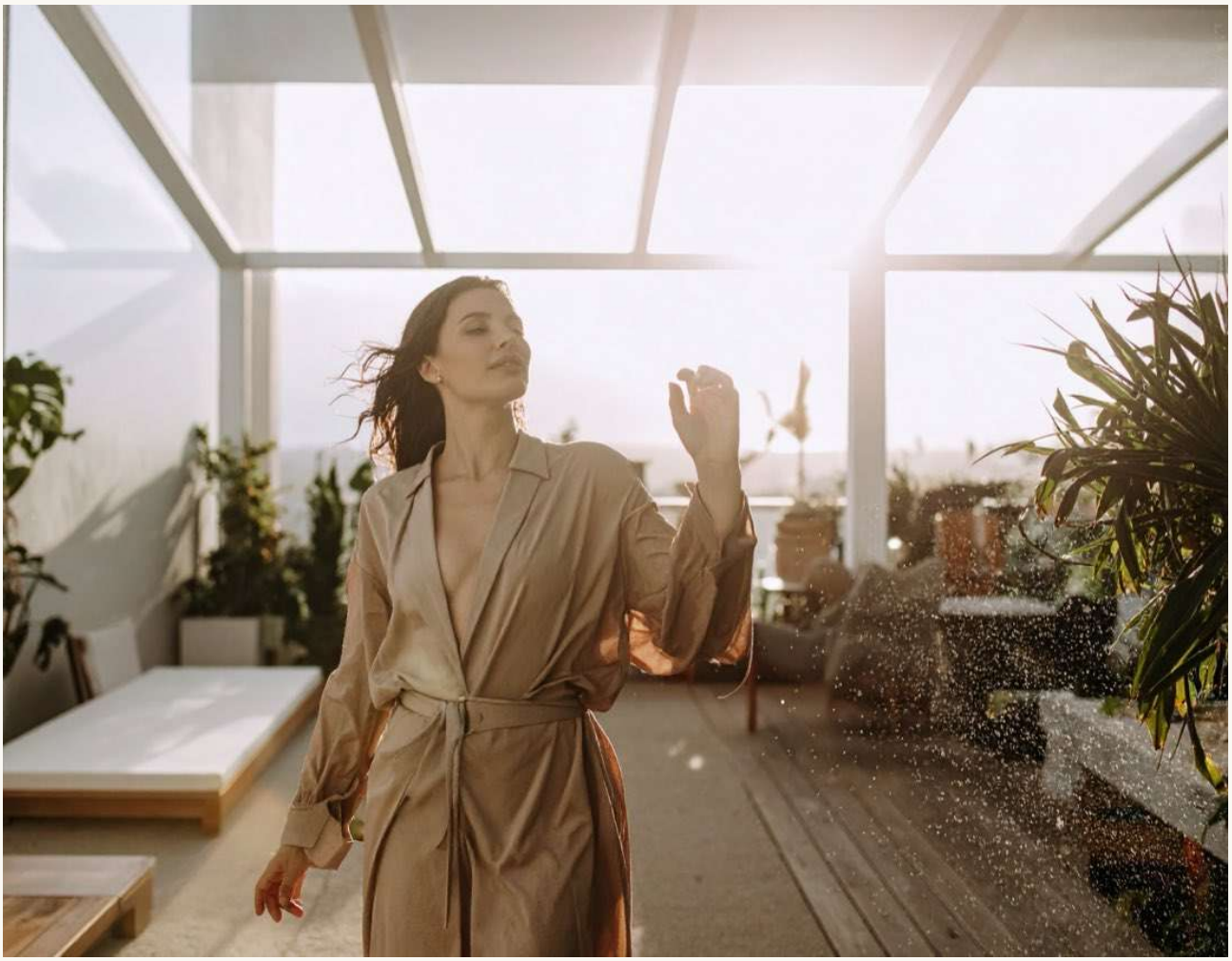
ABSTRACT

The nurse who fetches linen from another unit has solved the problem for her patients, and nobody who could stop it happening has been told. A nurse is working the night shift on an oncology floor, and she has run out of clean linen. Her patients' beds need changing, and the cupboard on her unit is empty. So she walks to another unit, one that has linen in stock, and takes what she needs from its supply. She takes more than one set. She brings back several, for the other nurses on her floor. It takes her a few minutes. The beds are changed. Nobody is told. This nurse is not a composite. She was observed on an American hospital floor by the researchers Anita Tucker and Amy Edmondson, who described her in a paper published in 2003. When they asked her about it, she said this:

CHAPTER FOUR

The Person Who Already Knows

The nurse who fetches linen from another unit has solved the problem for her patients, and nobody who could stop it happening has been told.



The Person Who Already Knows

HAUTE LUMIÈRE · WHERE THE FLOW STOPS · CHAPTER FOUR

Clean linen, the night shift

A nurse is working the night shift on an oncology floor, and she has run out of clean linen. Her patients' beds need changing, and the cupboard on her unit is empty. So she walks to another unit, one that has linen in stock, and takes what she needs from its supply. She takes more than one set. She brings back several, for the other nurses on her floor. It takes her a few minutes. The beds are changed. Nobody is told.

This nurse is not a composite. She was observed on an American hospital floor by the researchers Anita Tucker and Amy Edmondson, who described her in a paper published in 2003.[26] When they asked her about it, she said this:

> *"Working around problems is just part of my job. By being able to get IV bags or whatever else I need, it enables me to do my job and to have a positive impact on a person's life—like being able to get them clean linen. And I am the kind of person who does not just get one set of linen, I will bring back several for the other nurses."*

Every manager would want her on the team. She is resourceful, generous and calm. And her resourcefulness is, in the researchers' account, exactly why the hospital will run out of linen again next week. The problem was solved for her patients. It was never reported to anyone who could stop it happening, and the several sets she carried back left a gap in the other unit's cupboard that someone there would solve the same way.

Ammanuel Santa Anna's canon, writing about who in an organisation can see what, puts the nurse's position in two sentences that hold the whole difficulty:[27] "Senior leaders typically have broad but shallow visibility — they see strategic patterns and cross-functional dynamics but may miss the lived reality of frontline work. Frontline workers have deep but narrow visibility — they know their process intimately but may not see how it connects to the larger system." The nurse knows the linen runs out. The hospital, which pays her, does not.

A nurse in her position carries the difference in her body, though few would put it that way. The walk to another unit is a few minutes, taken from patients on a shift that had no minutes to spare, and the paper records the feeling that comes with getting back: seven of the nine nurses interviewed said they felt gratified when they found a way round an obstacle. The gratification is real, and it sits on top of a tiredness it does not lift. Each time a nurse solves the problem this way, she also confirms, to herself and to anyone watching, that this is a problem a good nurse solves alone.

This chapter makes one claim. The largest unclaimed asset in most organisations is the knowledge of the people closest to the work: what fails, how often, and how they get round it. The organisation has already paid for it, in wages and in years of experience, and it spends that knowledge every day on fixing the same problems again, rather than collecting it once and removing them. The gain is in the difference, and the people who hold the knowledge should share in what it is worth.

Thirty-three minutes a shift

Tucker and Edmondson's study was patient work. They observed twenty-six nurses at nine hospitals for a total of two hundred and thirty-nine hours, recording every problem that blocked a nurse from finishing a task, and then interviewed twelve of the nurses at seven of the hospitals. The problems they recorded were not exotic. In their own list: missing medications, regular-diet food trays delivered for diabetic patients, insufficient supplies, and missing medical orders. They were, the authors wrote, "relatively straightforward and embedded in routine processes."

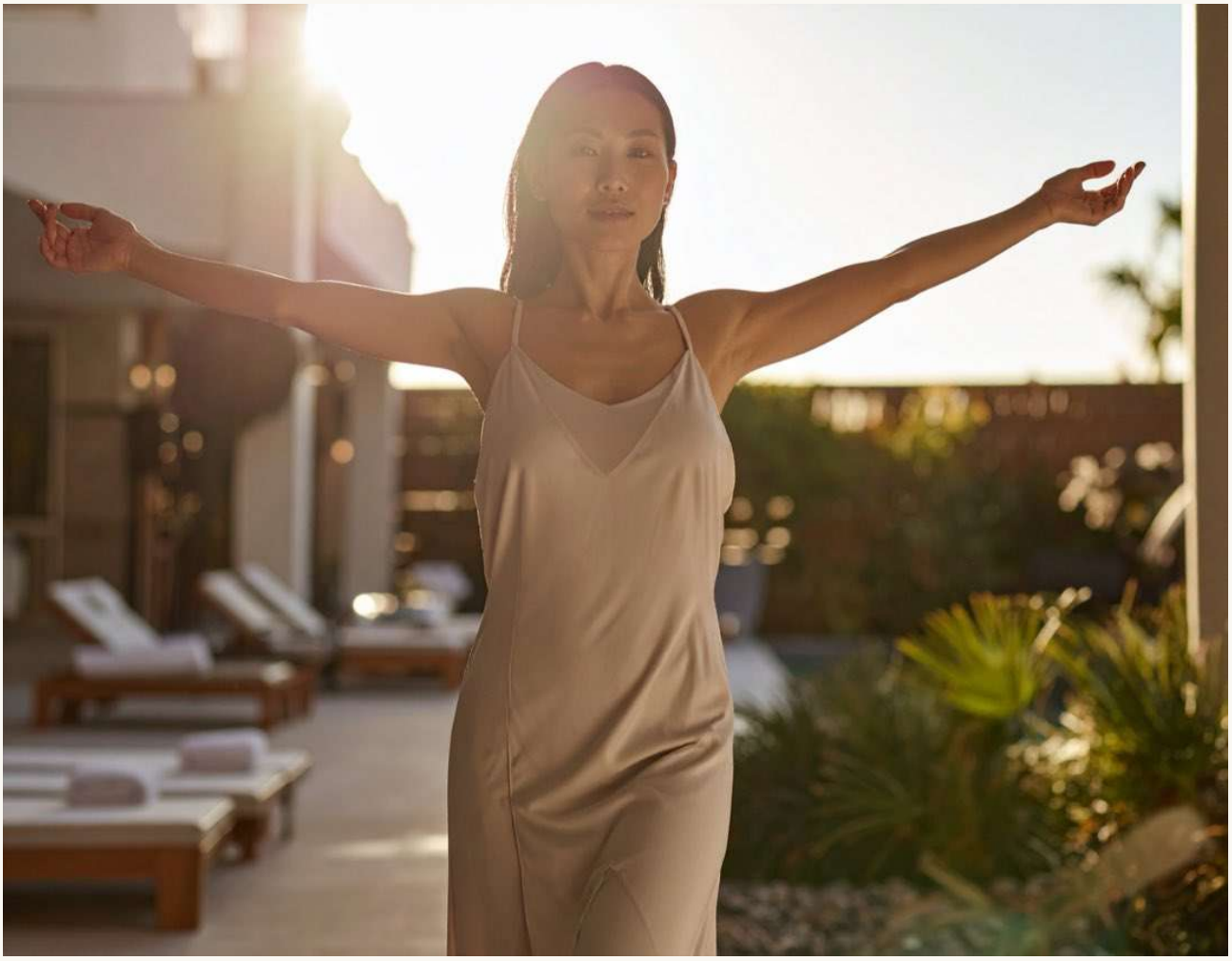
What the nurses did about them was remarkably consistent. The researchers distinguished two kinds of response. In what they called first-order problem solving, the worker gets the supplies or information needed to finish the blocked task and carries on, without addressing why it was blocked. In second-order problem solving, the worker also does something to change the underlying cause: tells the person responsible, raises it with a manager, suggests a fix. The nurses used the first kind, the researchers found, for ninety-three per cent of the problems. Only seven per cent of responses met even lenient criteria for the second.

Then they counted the cost. On average, they estimated, thirty-three minutes were lost per eight-hour shift to coping with system failures that could have been addressed and removed. That is the time of highly trained professionals, every shift, spent on work that need not exist. It is a figure from observation, in American hospitals, two decades ago, and it should be read with those limits. It is also one of the few places in the literature where the cost of the front line's silent knowledge has been measured at all.

It is worth doing the simplest arithmetic on it, because the arithmetic is what a finance director would do. Thirty-three minutes is a little under seven per cent of an eight-hour shift. On a unit that staffs several nurses on every shift, every day of the year, that is the equivalent of a substantial part of a nurse's working time, spent not on patients but on the same missing trays, absent orders and empty cupboards, found and worked round again and again. The calculation is not the paper's; it is the paper's figure set beside the ordinary facts of a ward, and any hospital could do it with its own rota. Almost none does, because the thirty-three minutes appear on no report. They are absorbed, quietly, by people who stay late.

The researchers' explanation of why it happens is the part that should interest any leader, because it is not what a leader would guess. It was not, they wrote, that the problems were hard, nor that the nurses were unmotivated. The nurses were dedicated and capable; most of those observed for a full shift stayed after it ended, unpaid, to finish their patients' care. The pattern was produced by three things hospitals value. A professional norm of individual vigilance taught each nurse to solve her own problems. Lean staffing left no slack to do anything else. And a goal of empowerment, of units able to run without managers, meant nobody above the nurse was there to hear. Each of these is a virtue. Together they produced what the paper calls an illusory equilibrium, a system that felt as if it were coping while it slowly wore out the people coping with it.

Santa Anna's canon has a sentence for the knowledge in that equilibrium, and it fits the linen cupboard exactly. "The truth was never hidden. It was only unspoken. And the difference between hidden and unspoken is the difference between ignorance and courage." The hospital was not ignorant that linen ran out. Some of its staff knew it every night. The knowledge simply never travelled.



Breakfast with the technicians

HAUTE LUMIÈRE · WHERE THE FLOW STOPS · CHAPTER FOUR

Breakfast with the technicians

Tucker and Edmondson's nurses are one well-documented case of a pattern that turns up wherever researchers watch work closely. Another is a group of copier repair technicians studied in the 1980s by the anthropologist Julian Orr, who worked alongside them, and whose book *Talking About Machines* (1996) is one of the classic workplace ethnographies.[28]

The technicians, as John Seely Brown and Paul Duguid described Orr's findings in a widely read 1991 paper, were issued with documentation that told them how to diagnose faults by following a decision tree.[29] The

machines did not always fail in the ways the documentation expected. So the technicians did what skilled people do. They met, over breakfast and lunch and in the car park, and told each other stories about difficult machines, and in the telling they built and shared a working knowledge of faults that the official procedures did not contain. The real diagnostic expertise of the organisation lived in those conversations. Brown and Duguid's abstract puts the general finding plainly: the ways people actually work "usually differ fundamentally from the ways organizations describe that work in manuals, training programs, organizational charts, and job descriptions." And organisations, they noted, tend to rely on the descriptions.

Orr's is a single ethnography of one occupation in one company, and its strength is depth rather than reach. Its finding has been repeated in many other settings, and the philosopher Michael Polanyi had given the underlying idea its best-known form in 1966, in *The Tacit Dimension*: we can know more than we can tell.[30] The nurse knows which unit keeps linen at three in the morning. The technician knows the sound a particular model makes before a fault. Neither experiences this as knowledge; they experience it as how the job is done. That is precisely why it is so seldom collected. Nobody thinks to offer what they do not think of as theirs to offer.

Organisations that notice the problem usually try to solve it by writing things down. They commission a knowledge base, a lessons-learned database, a library of procedures, and the front line is asked to contribute. The effort is well meant and its results are usually thin, for the reason Orr's technicians make plain. Their knowledge was not a set of facts waiting to be recorded. It lived in the telling, in the back-and-forth over a particular machine, in a colleague's question that jogged a memory. Asked to fill in a form, the same technicians would have written down very little, because very little of what they knew took the shape of a form. What collected their knowledge was the breakfast table, and the organisation had not designed the breakfast table. It had merely failed to prevent it.

That is the practical lesson of this research for anyone who runs something. Frontline knowledge is collected mostly through conversation, with someone who can act, at the place and time the work happens. It is collected poorly through systems designed by people far from the work, however good the software.

The economist Friedrich Hayek, writing in 1945 about why central planning fails, made the same point at the scale of an economy.[31] The knowledge that matters most for decisions, he argued, is often not scientific knowledge but "the knowledge of the particular circumstances of time and place", and it is held, dispersed and in fragments, by the people on the spot. Hayek used the argument for prices and markets. It applies with equal force inside a firm, which is a small planned economy whose planners sit furthest from the particular circumstances.

The comparison is not as abstract as it sounds. Inside a firm, prices do not carry information from the floor to the top; reports do, and reports are written by people with reasons to keep them tidy. A market finds out quickly when a supplier is unreliable, because buyers go elsewhere. A hospital finds out slowly that its linen service is unreliable, because its nurses do not go elsewhere. They go to the next floor. The particular

circumstances of time and place are known on every ward at three in the morning, and the planning is done in an office at ten, from a dashboard that has never heard of them.

What the middle sees

If the knowledge is at the front line and the authority to use it is at the top, the obvious place for it to cross is the middle of the organisation. Santa Anna's canon is unusually precise about why it so often does not. Middle managers, it says, "see enough to know that the view from the top does not match the reality at the bottom, but they often lack the authority to act on this knowledge and may be incentivized to smooth the discrepancy rather than surface it."

That sentence describes a nurse manager on a floor like that one, a composite drawn from the paper's account of how units were run, and no hospital is meant. She knows the linen runs short; she has heard about it for months. Her budget is measured on the unit's costs, and the linen comes from a central service she does not control, and raising it again would mark her as a manager whose unit complains. So she smooths it. Her nurses cope, and the cost appears nowhere, because coping is free on every report the hospital produces.

From the top of the hospital the view is clean. The dashboard shows bed occupancy, length of stay, staffing ratios and the cost of the linen contract, which is under budget. Nothing on it says that nurses on three floors spend part of every night walking to other floors for sheets. The senior team is not careless; it reads what it is given, and what it is given has been smoothed twice, once by the nurses who coped and once by the managers who did not report the coping. The canon's phrase for this is broad but shallow visibility. The breadth is real, and so is the shallowness, and the shallowness is not a failing of the people at the top. It is a property of where they stand.

Tucker and Edmondson's sharpest recommendation is addressed to exactly this smoothing, and it inverts what most managers would call a good employee. The ideal employee for organisational learning, they wrote, is not the one who handles any problem without bothering anyone. It is "a noisy complainer, who speaks up to managers and others about the situation, thereby running the risk of being seen as someone who lacks self-sufficiency." It is a startling phrase for a management journal, and it is meant to be. The nurse with the linen was the ideal employee by every measure the hospital used, and the least useful employee for the hospital's learning.

The canon adds the reason the noisy complainer is so rarely believed when she does speak. In most organisations, it says, the executive's observations carry more weight than the frontline worker's, "not because they are more accurate but because the social field assigns them more authority." A report from the floor arrives at a meeting already discounted. *The Cairn*, another of the house's books, reads [the order of the questions in a weekly review, and what that order teaches](https://hautelumiere.life/editions/rsd-rsd-and-

self-confidence/page/); a review that begins with the senior person's account of the week has told the front line, before anyone speaks, whose account counts.

Paid for once, collected never

Put the pieces together and the shape of the gain is clear, even where its size is not. Every organisation employs people who know, specifically and from experience, where its processes fail. It pays for that knowledge every month. It then spends the knowledge on workarounds, thirty-three minutes a shift on one hospital floor, an unknown amount everywhere else, and the problems recur because the people who could remove them never hear of them. The knowledge is paid for once and collected never.

This is not a new observation, and the house is careful not to present it as one. The oldest serious attempt to collect what the people doing the work know, and to share with them what it turns out to be worth, began in a failing steel mill in the late 1930s, and its long record of committees, studies, successes and failures is the subject of a whole book in the economics line, The Gain Was Always Shared. That book reads the evidence on gainsharing with its limits; this chapter does not repeat it. What this chapter adds is the frontline research of the last thirty years, which shows from the other side why such plans work when they do. A plan that pays for ideas without changing who listens has not touched the nurse's equilibrium. A plan that changes who listens, and then shares the gain, has.

The pattern is not confined to hospitals, and leaders outside medicine should resist the comfort of thinking it is. The claims handler who knows which three fields on the form cause most of the rework. The warehouse picker who knows that two bin locations are swapped on the system and has been correcting for it, in her head, for a year. The order clerk in Chapter 2, who knew that model 4 comes in two versions and checked it on every call, while newer clerks did not. Each of them is a nurse with linen. Each is coping, competently, with a fault that someone with authority could remove in an afternoon, and each would describe what they do not as knowledge but as the job.

Santa Anna's *Ecstatic Economics* describes the principle in terms of feedback, and it is the right word. Extractive arrangements, the book argues, sever the connection between what people do and what it produces; its alternatives restore it. Among its examples is "The worker-owner who shares in the consequences of business decisions," and its summary of what all of them achieve is a single image: "In each case, the feedback loop that extractive economics severed has been sutured back together." The nurse's loop is severed twice. Her knowledge of the linen does not reach anyone who can fix it, and the value of fixing it, which would be real, would not reach her.

There is a further reason the people who already know should share in what their knowledge is worth, and it is practical rather than moral. Second-order problem solving costs the person who does it. It takes time she does not have, it risks the label of complainer, and it gives her nothing she did not already have, since

she had already found the linen. A firm that wants the second kind of problem solving is asking its people to take on cost for the firm's benefit. Sharing the gain is how the firm stops asking for that as a favour.

Sharing also changes what the second kind of problem solving means to the people around the one who does it. In a firm where speaking up about a fault earns nothing, the person who does it is a complainer, and the label sticks because there is no other explanation for her behaviour. In a firm where a removed fault produces a measured gain and a visible share of it, the same person is the colleague who found the thing that paid for the team's year. The behaviour is identical. Its social meaning is reversed, and social meaning, as the research on silence in the earlier chapters found again and again, is what decides whether people speak. A share in the gain is not only a reward. It is a public statement, in the one language every organisation reads, that the person who already knew was right to say so. *The Cairn*, another of the house's books, reads [the second file of recognition other people keep about us](https://hautelumiere.life/editions/rsd-rsd-and-self-confidence/page/); a share in a measured gain is that file written in the firm's own accounts.



The other nurse

HAUTE LUMIÈRE · WHERE THE FLOW STOPS · CHAPTER FOUR

The other nurse

Tucker and Edmondson's paper contains a second scene, and it is the one this chapter would have its readers keep. An inexperienced intensive-care nurse transferred a two-year-old patient to the oncology floor and, rather than wake the sleeping child, left him on the specialised intensive-care bed, which needed to go back. Half an hour later the intensive-care unit's nurse manager rang the oncology floor asking for it.

The oncology nurse could simply have returned the bed. That would have been first-order problem solving, and nobody would have faulted her. Instead she rang the intensive-care nurse manager, and said, in the words the researchers recorded: "I don't want to get anyone in trouble, but I want you to know what happened so you can talk to the nurse so that it does not happen again."

The researchers noted the apology at the start of her sentence. It is, they suggested, a sign of how much against the grain her small act was. She had to excuse herself for helping the hospital learn.

What changes this, in practice, is a manager who makes that sentence ordinary. Picture that same composite nurse manager deciding to try. She does three things, in the order the research suggests. She is present, for part of every shift, including nights, because Tucker and Edmondson observed that managers who were physically there were told about problems that managers who were not never heard of. She keeps one place, a page on the wall of the staff room, where any nurse can write a problem in a line, and she reads it every day. And she answers every line, within a week, with what was done or why nothing could be, because the paper's third lever is follow-through, and one of its nurses had put the cost of its absence in a sentence: "No one seems to listen and now no one bothers trying."

The first week the page has eleven lines on it, four of them about linen. The manager takes the four, together, to the central linen service, with dates and times, and the service changes the night delivery. She writes the change on the page beside the four lines, with the names of the nurses who wrote them. The second week the page has nineteen. Several of the lines she cannot fix, and she says so, on the page, with the reason: the pharmacy's delivery times are set by a contract she cannot change this year, and she has raised it with the person who can. That answer, it turns out, is nearly as useful to the floor as a fix. It tells the nurses their line was read by someone who took it seriously, and it tells them where the problem now sits.

The manager notices something about herself in the first month that surprises her. She has her own workarounds. When a nurse is off sick at short notice, she covers the gap by ringing round her own list of people who say yes, and she has never told anyone above her how often she does it. She is, in her own position, the nurse with the linen. The page on the staff-room wall acquires a line in her handwriting. Chapter 7 carries the run sheet for this practice, and Chapter 6 places it in the order of a first ninety days.

None of this is expensive, and all of it is easy to stop doing. The page becomes a suggestion box that nobody reads. The manager answers for a month and then gets busy. The follow-through becomes a form. Each failure teaches the floor, faster than the success taught it, that the old equilibrium was the real one. What keeps it going is the same thing that kept the workarounds going: it has to be easier, for the person who knows, to say so than to cope.

None of it works if the page becomes, in the canon's terms, a poster rather than a body. The line has to be written in a room where asking is safe, the subject of Chapter 3, and that is decided by what the manager does when the first awkward line appears.

The minutes it frees become money only when they can be counted, and Chapter 5 shows why the counting has to be agreed before the first line is fixed, in a form both sides would sign, or the nurses who wrote the lines will be the last to be credited with what they found.

Collecting what the front line knows

The page on the staff-room wall is the simplest collection system there is, and its simplicity is the point. The book can carry the details that decide whether it works.

One line, in the person's own words, at the place the work happens. The page asks for a problem in a sentence, with a date and, if the writer is willing, a name. It does not ask for a cause, a solution or a category, because each of those is a barrier to writing anything at all. A nurse at three in the morning can write *no clean linen, 03:10* on her way past. She cannot fill in a form.

Read it every day, and answer within a week. Tucker and Edmondson's third lever was follow-through, and its practical form is a promise that every line receives one of three answers within a fixed time: fixed, with what was done; cannot be fixed now, with the reason and who now holds it; or passed to someone named, with the date it was passed. The second answer is as valuable as the first. A line that receives no answer is worse than no page, because it confirms what the nurse who said nobody listens already believed.

Group the lines before acting on them. Four lines about linen on four nights are one problem with four pieces of evidence, and they carry far more weight with a central service than any single complaint. The manager's job is to see the pattern and take it, with its dates and times, to the person who can change the system. This is second-order problem solving done on the front line's behalf, by the one person on the floor with the standing to do it.

Be present. The paper observed that managers who were physically on the unit, for part of every shift, learned of problems that absent managers never heard about. There is no substitute. A page can collect what people are willing to write; a manager on the floor at night hears what they would never think to write, because to them it is simply how the job is done.

Give credit by name, with permission. When a line leads to a change, the change is written next to it with the names of the people who reported it, if they agree. This does two things. It makes the noisy complainer of the research a visible contributor, which reverses the social meaning of speaking up. And it creates the record that Chapter 5 needs: a dated account of who found what, before anyone has measured what it was worth.

Resist the knowledge base. Sooner or later someone will propose turning the page into a system, with fields, categories and a dashboard. The research on Orr's technicians is a warning. Much of what the front line knows lives in conversation and in the moment, and it is collected best by someone who can act standing next to someone who knows. A system can come later, as a record of what the conversations produced. It cannot replace them.

Watch your own workarounds. The manager in this chapter found that she was herself the nurse with the linen, covering gaps by ringing round people who said yes and telling nobody. Every manager has such habits, and they are invisible to her for the same reason the nurse's were invisible to the hospital. Writing

one of them on the page, in her own hand, is the most effective thing she can do to show that the page is meant.

Chapter 6 places the page in the second month of a ninety-day plan, once the round of Chapter 3 has made speaking ordinary, and Chapter 7 gives the page's layout, the three answers and the grouping rule.

Clean linen, a week later

It is the night shift on the oncology floor, and the linen cupboard has clean linen in it. The delivery that used to come at six in the morning now comes at ten at night, because four nurses wrote down, on four nights, when the cupboard ran out, and someone read what they wrote.

A nurse changes her patients' beds without leaving the unit. It takes the few minutes it always took. The difference is the walk she does not make, to a cupboard on another floor, and the gap she does not leave there.

On the page by the staff-room door, under the four lines about linen, there is a fifth in a different hand. It says the infusion pumps on the left-hand side of the ward are always the last to be charged. It is dated tonight.

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The Person Who Already Knows

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