FIELD NOTES · LEADERSHIP, OPERATIONS AND CROSS-BORDER CARE

Best of the field notes

Ten notes on running healthcare operations across borders, by Rolston Paul.

I write field notes on the operating side of care: how one standard holds in many clinics, how quality gets reviewed from a distance, and what a patient needs before they travel and after they fly home. These are the ten I would hand first to an operator in another market.

Nothing in this file is new. Each note keeps its key points exactly as they appear on rolstonpaul.com, with a link to the full note and its sources. If one of them describes a problem you have this week, read the full note first.

01	One promise, many clinics: writing a franchise operating standard that travels
02	Invariants and local choices: the only two lists a franchise standard needs
03	Escalation paths that work and paths that stall
04	The after-action review, adapted for the operating theatre
05	Reviewing surgical quality when you cannot be in the room
06	Complications abroad: the medical tourism plan you write before the first patient lands
07	Medical tourism aftercare: the records that must travel home
08	Transparent medical tourism pricing starts with a written scope
09	Follow-up is a system, not a habit
10	Buy, build or refuse: an automation decision that survives the demo

Built 14 November 2026 from rolstonpaul.com · rolstonpaul.com/best-of-the-field-notes.pdf

01 / KEY POINTS

One promise, many clinics: writing a franchise operating standard that travels

- A standard is what happens in the room when nobody is watching.
- Start by sorting everything in the manual into two lists.
- The format I use fits on one page per procedure.
- The strongest argument for building evidence into the work is that self reported compliance is close to worthless.
- The same narrative review makes a second point worth stealing.

Full note and sources: rolstonpaul.com/writing/one-promise-many-clinics-writing-a-franchise-operating-standard

02 / KEY POINTS

Invariants and local choices: the only two lists a franchise standard needs

- Open any operating manual and read the verbs.
- I use the two-list model as a practical design method: protect the commitments the network must keep and state where local teams can choose their approach.
- Four questions, and a rule has to pass all four.
- The second list usually gets treated as a residue, whatever the manual did not mention.
- How a franchisee reads a document you are not in the room for is outside your control.

Full note and sources: rolstonpaul.com/writing/invariants-and-local-choices-the-two-lists-a-standard-needs

03 / KEY POINTS

Escalation paths that work and paths that stall

- The map needs three columns: the trigger event, the owner who must act and the time limit for action.
- When a document is flagged as missing, I trigger the document-gap workflow.
- I require the outgoing shift to write a hand-over note that lists pending tickets, patient urgency level and any open escalations.
- Each month I pull a report of all escalations that reached the second tier or higher.
- I ask the liaison team to send a status email within one hour of any escalation trigger.

Full note and sources: rolstonpaul.com/writing/escalation-paths-that-work-and-paths-that-stall

04 / KEY POINTS

The after-action review, adapted for the operating theatre

- NHS England's patient safety learning response toolkit lists the after action review among its learning response methods, alongside the swarm huddle, the multidisciplinary team review and the patient safety incident investigation.
- The WHO Surgical Safety Checklist asks the whole team to pause at three points: before anaesthesia, before incision and before the patient leaves the operating room.
- Keep the four questions in sequence, because skipping ahead to fixes is the usual way these conversations fail.
- The facilitator should not be the most senior clinician in the room.
- A single theatre can improve on its own.

Full note and sources: rolstonpaul.com/writing/the-after-action-review-adapted-for-the-operating-theatre

05 / KEY POINTS

Reviewing surgical quality when you cannot be in the room

- A request to review the session is too broad.
- The evidence should tell the sequence of the work, from planning through execution to documentation and outcome, in an order the reviewer does not have to guess at.
- I ask for a consistent context record: what was expected, what changed, when it became known, what was decided and which constraint shaped the decision.
- The fastest way to lose a surgeon's trust from a distance is to jump from a partial image to a verdict about competence.
- A long review report proves effort and changes nothing.

Full note and sources: rolstonpaul.com/writing/reviewing-surgical-quality-remotely

06 / KEY POINTS

Complications abroad: the medical tourism plan you write before the first patient lands

- Most complication plans fail at the same point.
- The flight home is part of the treatment and should be planned like it.
- The last stretch of complication management is a person, not a file.

Full note and sources: rolstonpaul.com/writing/complications-abroad-the-plan-you-write-first

07 / KEY POINTS

Medical tourism aftercare: the records that must travel home

- The first question goes to the clinical lead: what details must be on hand for this patient's follow-up?
- I would use a document register showing the required item, its clinical author or approver, the current version and its delivery status.
- A departure date can make an unfinished handover feel like an administrative inconvenience.
- The handover record should stay open for the actions the service has agreed to finish after departure.

Full note and sources: rolstonpaul.com/writing/records-that-travel-home-aftercare-designed-for-the-flight

08 / KEY POINTS

Transparent medical tourism pricing starts with a written scope

- I would ask the clinical team to name the approved scope and any assessment still needed.
- I would describe the parts of the service in words the patient can use.
- I would give aftercare a visible place in the quotation conversation.
- I would compare a sample of quotations with the approved scope, the service delivered and any recorded revisions.

Full note and sources: rolstonpaul.com/writing/transparent-written-pricing-the-document-that-changes-a-medical

09 / KEY POINTS

Follow-up is a system, not a habit

- Patients abroad often take weeks to decide, and a clinic that goes silent or chases too hard loses their trust either way.
- Every follow-up message should keep a few simple rules.
- A default schedule helps when the patient has not chosen a date.
- Three numbers get my review each month, by seller and by market.

Full note and sources: rolstonpaul.com/writing/follow-up-is-a-system-not-a-habit

10 / KEY POINTS

Buy, build or refuse: an automation decision that survives the demo

- The business case needs an explicit benefit, an owner and a stopping condition.
- Anyone facing an automation decision on Monday morning should have this sheet in front of them.
- Once the gates are clear, the buy or build split is much less interesting than people make it.
- Build when the process is the thing that makes your operation different from the clinic across the road, and when you already run it well manually.
- A demo is a sales asset, and a good one is honest about the product and silent about the conditions.

Full note and sources: rolstonpaul.com/writing/buy-build-or-refuse-an-automation-decision-that-survives

NEXT

Tell me what you are trying to fix.

Write to me at info@rolstonpaul.com. New notes arrive by email: rolstonpaul.com/newsletter.

Every key point is a sentence taken word for word from the linked note. No employer, client or patient is named.