Episode four - Schism between quality and safety

Debbie Draybi: I'm Debbie Draybi from the Clinical Excellence Commission and I am pleased you can join us for this four-part podcast series with George Douros. This podcast is part four of a four-part series on Listen up for Safety. In this segment, part four: Schism between quality and safety, George talks about the difference between a complicated and complex system and describes the importance of Safety II in understanding the complexities of health care.

We spend a lot of time focusing on what went wrong and there are significant opportunities in learning from when things go well. George uses the analogy of limitations of Safety I with how we don't understand how to have a successful marriage by just looking at divorce. The key to understanding the complexities in healthcare is focus on when things go right and why they go right. Compliance in a complex system is not always relevant and that clinicians have this incredible capacity to adapt and change.

Dr George Douros: The other thing that we have to bear in mind is that there's a bit of a schism between quality and safety in that quality comes from manufacturing - eg: building an iPhone - and any manufacturing is merely a complicated process. And an iPhone has hundreds if not thousands of little parts to it, but there's only one way to make an iPhone. If you deviate at all from that, it's not an iPhone and it doesn't work, so mindless compliance equals the right thing happening. In healthcare it's different because there are so many unknowns.

If you just think of a category two chest pain presenting to an emergency department: Depending on which hospital, what time of day, how they described the chest pain, an infinite number of things could happen, and you need to be using clinical judgment to figure out where the patient can actually go.

The trouble is that a lot of the people who are designing the systems don't actually realise the difference between a complicated system - where mindless compliance is good - versus a complex system where you perpetually have to reassess to decide what the next thing is.

If we're all mindlessly compliant, the entire system would be a disaster. But quite often what we do is every time there's an incident, we pick out a policy and say "you should have followed this. Please follow our policies in the future". If you look at when things go right, we don't follow the policies all that often either, because we have to go off script a lot of the time in order to get the right thing done.

But if you're only investigating bad things rather than good things, you'd come to the conclusion of "Well, you're just not following policy, what's wrong with you people?"

So that's the one of the problems - the schism between quality and safety in terms of the difference between a complicated and complex pathway, and also the problem with only looking at adverse incidents and not looking at all incidents, so called Safety II.

Debbie: Yes, I know you've written a lot in that space around Safety II and referred to a lot of the literature in that area. I wouldn't mind talking a bit more about that because what you're describing there is missed opportunity to understand the complexities of the system, if we're

only talking about when things go wrong. And then there's a lot of literature now and evidence around the importance of exploring when things go well and the key learnings from that.

George: Yes, probably the best saying is the way that we approach safety is if we're looking at divorce and we're trying to figure out how to have a successful marriage by just looking at divorces. When there's far more opportunity to look at what the positive capacities of when things go well and by things going well, I'm not just referring to the awesome and amazing two percenters of the heroic doctors out there, I'm talking about the 90% of everyday work when things go right.

We have this default that we think when things go right, we're following policy. But if you actually look at it, often we're not, and we have to adapt to get things done and diagnosis is the perfect example of this. How we have to perpetually adapt because what the patient is experiencing is changing. What he says to one person is different to what they say to another, and there are so many opportunities for things to go wrong as well as right. If we can actually figure out when things go right - and why they go right - we can try to increase those positive capacities.

Debbie: Absolutely and you talk about that in terms of really getting a sense of how we adapt and we're doing that 90% of the time, constantly adapting to the complex systems that we're working in. And then there's a real missed opportunity if we're not exploring that 90% of the time, isn't there?

George: Yes. I'll give you an example of a missed aortic dissection, much like every other hospital we had another one just recently and the safety department pointed out that we'd missed another one as well as one two years ago so why is this always happening? But when you look at the literature, the literature says the average miss is 30%. Over the last 15 years we've only missed six percent of them, so we're actually better than average.

And whilst they're saying cognitive bias and non-cognitive bias, it's like, well, can you tell us how we get it right 94% of the time because you seem to know what's wrong, when we when we get it wrong in the six percent so what are we doing differently? And it's like what do you mean? There isn't that concept, so that's what Safety II is. It's like, well, perhaps rather than telling people off when they get it wrong, we should be looking at what we did differently when we got it right.

Debbie: Yes, absolutely. And the importance of learning from those experiences which happened the majority of the time and as you said, people come to work to do the right thing and mostly they do get it right. It's just we're not really exploring that, and the mindset just isn't there yet for Safety II is it?

George: Look, it's starting up in a few places. There are the Resilient Healthcare guys that have been based in Holland that I think are actually moving to Sydney soon. As well there's just a few people popping up here and there. There's an intensivist in NZ called Carl Horsley whose paediatric intensive care department is doing a lot of work in that space and some very impressive stuff, but we've got a long way to go.

Episode four - Schism between quality and safety

Debbie: Look, I think you've done an incredible job in the work that you've done to help support this journey towards improving not just the M&M space, but in enhancing the voice of clinicians and really noticing the importance of being able to listen to them and give them that opportunity to share their experiences rather than only notice them when things go wrong. Is there anything else that you haven't talked about that you think would be important to mention for M&Ms and in supporting and enhancing leadership?

George: I think I've got a 'take home' to gauge how effective you are at the end of your M&M and this is a great quote: "Learning implies changing. What's changed?" So, if you think you've done something and actually achieved some change, just stop and think what it is. Was it literally a change to your system, or have you just told people to try harder because if that's all you've done, you've done nothing. And sometimes the cause of the problem and the solution of the problem can be different.

Debbie: Thank you for listening to this podcast with Dr George Douros - Listening up for safety. I hope you enjoyed it. Please note this is one of a four-part series and I hope you listen to the other three segments as George continues takes us on a journey exploring his passion for patient safety and how Human Factors science has supported his work as an emergency physician in improving M&Ms. Listen in as we discuss their insight and lessons learnt from experience of supporting the leadership in M&Ms.