Episode three – Listen up for 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 three of a four-part series on Listening up for Safety. In this segment, Listen up for safety, George talks about communication as a two-way street and the importance of listening up for safety. Whilst we encourage our clinicians to speak up for safety this is not effective unless our senior clinicians and administrators are listening up for safety.

George gives some practical examples of the importance of M&M chairs to be trained facilitators establishing in what Amy Edmondson calls a psychologically safe space in M&M where senior staff listen up for safety. George emphasises the facilitator's role to be aware of how blame can happen and it's their responsibility to call it out and control it and make a psychologically safe space.

Debbie: In the safety and quality world we talk a lot about speaking up for safety, but you've emphasised the importance of moving that a step further, and it's about listening for safety and we know that we haven't done that well.

Dr George Douros: So, once again, medicine has partially grabbed the concept - the speaking up for safety concept and this started with them figuring this out in the airline industry. Korean Airlines had fantastic new planes and incredibly well-trained pilots, but they had more accidents than other people and what they found was that the way the Boeing jets were designed was for two equal peers to be communicating on the same level. But Korean culture is very hierarchical to the point that the co-pilot could never challenge the pilot. And so, there was a time where the pilot was just fixated on this knob that wasn't working and, even though the co-pilot saw it coming, they just flew straight into a mountain because nobody could say anything.

But what Korean Airlines successfully did was not just train the co-pilots to shout louder, they actually had to train the pilots to listen up for safety. And this is the key thing. If you are telling your junior staff to *speak up for safety*, you've got to tell your senior staff to *listen up for safety*. It's a two-way street, method of communication. I've been on a root cause analysis where one of the recommendations is that the junior staff get trained on speaking up for safety, but the safety department was too scared to even name a terror that actually worked in that department because of the power that that person had. And rather than addressing that, they were telling the most junior of junior people, you need to speak up, and that's unfair.

You have to create what Amy Edmondson calls a *psychologically safe space* where you can actually speak up. And it's not just in the clinical environment, it's also in the administrative environment. I'll give you an airline example there as well with the Boeing 737 Max where two planes crashed in the last couple of years. The pilots had been telling Boeing that something was wrong, but the managers were saying "if we stop this now, it's going to cost money so we're not going to stop it/we're not going to listen to you". And they didn't listen, and two planes crashed, and the entire fleet was grounded for a year and a half. So, if you are asking your staff to speak up for safety, you need to listen up for safety and have the culture not only critically but also administratively in order for your department to be working well.

Debbie: Absolutely, and it's incredible with the examples that you use around the barriers that the power dynamics create. We've put in our guidelines the importance of creating a safe space for discussion, but we know more and more that, unfortunately, the M&Ms aren't always a safe space due to those power dynamics, and I'm wondering if you have some advice for the leadership of M&Ms on how they can produce or support creating a safer space, and how they can create an environment where they're listening to the juniors?

George: I guess one of the things if you're facilitating an M&M, in particular, is that you have to be a trained facilitator, and you've got to be ready to call out anybody when blame comes - whether it's from your own director or from someone else. Because if you're not speaking up for safety for a psychologically safe space, you've given permission for the entire place to remain a psychologically unsafe space. So, as the facilitator, you've got to *walk the walk* as well as *talk the talk* in this regard.

Debbie: Absolutely and they need to demonstrate in the way that they are facilitating and really giving permission, noticing where there is blame happening and then opening it up.

George: Yes, I think it's definitely the facilitator's role to be aware of how blame can happen and it's definitely their responsibility to call it out and control it and make a psychologically safe space. And that involves - whether it's in your department or with other departments – the protection of your team. Otherwise, you're sending the wrong message.

Debbie: And you mention in some of your literature the importance of ensuring that having an open discussion that's blame-free, it's not positioned in the way that it's staff making excuses for failure or not taking the incident seriously or acknowledging it as an error. Would you mind elaborating on that?

George: Yes. It's the mindset of the reviewer, again. You just have to look at what happens when someone taps you on the shoulder and says you've been involved in an incident. You'll quite often just say, these are the circumstances and you just list them off. This is the context as to how things happened as they did. If the person who's approaching you has the mindset of "this guy's the problem", then they're going to view everything they've said as excuses.

If though, the person who's doing the review says, "well, this guy was coming to do the right thing", and you view all the things they say as operational information about how the system was working at the time, then it's not excuses for failure, but operational information that you can use to prevent recurrence. If you dismiss all that stuff and say they are just excuses, all you're left with is "that person's an idiot, he needs to be punished" and there's your problem right there.

I can't emphasise enough how crucial the mindset of the person who's doing the review is. Oh, and one more thing: When you're doing a review - and this is something else that medicine doesn't do well - we view it through an organisational hierarchy lens. We think an M&M review is the lowest of the low, then you've got a safety department review which has to be better, then there's a sentinel event which is getting quite high up there, and then you've got the coroner's court review and that one's the definite gold standard. Look, that's

just an organisational lens. The actual persons who can do the best review are the people who were speaking to the people involved. Through my time in the coroner's court, I've seen sentinel events where the safety department hasn't spoken to anyone. They just fill in the form, tick some boxes and send it in as a sentinel event. That's a crap review. And not surprisingly, that review came up with human error as a cause.

We need to not view things through an organisational lens when it comes to investigations and this is one of the problems if your data that's collected from events goes into a great big database (a little bit like a meta-analysis). If you've got crap data going in, you're going to have crap data coming out. So, if there's a tick box that indicates 'human error' and everybody just keeps ticking that, then your database is just going to say, 'human error' and the problem's the people and we just need better people because the top one percent of the population isn't good enough.

Debbie: Yes, that's really critical what you're saying in terms of that mindset where you're able to really engage individuals who have been involved and who have what you've described as "a good understanding of the messy details of the work as done, rather than the perfect world as imagined." I think that's a really powerful statement that you're making in terms of being able to listen to them and have opportunities to share their experience rather than investigate what happened.

George: Yes, I'm glad you brought that up. First of all, any nice little phrase that you think I came up with didn't come from me but from the safety literature. There are people who are much smarter than me, but you raise a very, very, very important point which is the gap between work as imagined versus work as done. Basically, the people who design policies are quite often on the top floor and they don't know the messy details of 'work as done'. Eg: understaffing, too many people, access block, the CT scanner's down, the surgical registrar that doesn't respond to their pages, etc.

None of these little messy details actually make it into the notes. And it's very easy for those upstairs in the safety department on the fourth floor to have hindsight bias, to have outcome bias. You look at what happened. You know all the policies because that's your job. You pick out the right policy. You look down and say "noncompliance, there's your problem". And then you just punish the person involved or just tell everybody to please follow the guideline. But there's a couple of problems with that.

When you look at every single policy it will say "do ABCD" and then right at the bottom it'll say, "use your clinical judgment as to whether you apply it". And so, if a good thing happens, people just assume people followed the policy - whether they followed the policy or whether they chose their clinical judgment. If a bad thing that happens, what they'll say is "if you followed the policy, you should have used your clinical judgment, bad doctor" or if you used your clinical judgment and didn't follow the policy, they'll say "you're an idiot as you didn't follow the policy".

Far more important is to ask why did this seem like the right thing to do? And, quite often, you'll find that the reason why people were non-compliant with the policy that you know, with hindsight, should have been applied, is at the time they thought it didn't apply and they

were busy following another policy because they thought that that policy applied. So, the gap between *work as imagined* versus *work as done* is a very interesting space and is something that the safety science is really focused on, both for innovation and where possible errors can happen.

Debbie: Well, thank you George. It's been fantastic just hearing you share your experiences. I know you've used a lot of examples today from other industries, but you've also used some really practical health examples that bring some key learning from other industries that have worked really well. What's really stood out for me is your conversation and the example around aviation where they have a record of every flight where they openly talk about all their errors which are listed, and it's done in such a transparent way.

I feel like we still have a long way to go in our system for clinicians to be so open and comfortable to talk about their errors in such a transparent way.

George: Yes, and they will, if they feel psychologically safe to do so. It's a key thing.

Debbie: Absolutely and it's around the importance of creating that. You've given some really good examples of that today.

Debbie: Thank you for listening to this podcast with Dr George Douros and 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.

Debbie: I'm Debbie Draybi from the Clinical Excellence Commission and am pleased you can join us in this conversation with senior leaders on Guiding principles of effective Morbidity and Mortality in action. This podcast series aims to explore the experiences and insight from leading M&M meeting. Look out for more podcasts as we continue this conversation and clinicians share their journey and learning. I hope you find it useful and if you would like to contribute to this conversation please contact me.