CM: Welcome to Doctor Informed, brought to you by the BMJ, made in collaboration with THIS Institute and sponsored by Medical Protection. Doctor Informed aims to take you beyond medical knowledge. We're talking about all those things that you need to be a good doctor but which don't necessarily involve medicine.

I'm Clara Munro, I'm a Surgical Registrar in the North East England and I'm also a Clinical Editor here at the BMJ. In this episode we're going to be talking about blame. How it gets attributed when something goes wrong. How destructive it can be to creating all the space for improvement we've been talking about over this series. And how we can foster cultures that don't focus on whose fault it is.

To discuss that I'm joined by a new co-host. Those of you who have been paying close attention might have wondered what happened to Jenni who appeared in our trailer. Unfortunately Jenni's not been able to join us for the recordings, but very kindly her colleague Graham has agreed to step into the breach and help guide us through some of these complexities. Graham, could I get you to introduce yourself to our listeners?

GM: Hi, yes, I'm Graham Martin, I'm Director of Research at THIS Institute, the Healthcare Improvement Studies Institute. And yeah, looking forward to working with you for the next few episodes.

CM: It's really nice to have you on today, because I feel like you'll give us a theoretical understanding of some of the concepts that we apply when we talk about blame. And there's some terms that I think are often used when we talk about blame that maybe some of our listeners won't be familiar with.

I guess the one that immediately springs to mind for me is psychological safety. And I wonder if you might just touch on your understanding or provide a bit of an explanation on what psychological safety might be.

GM: So psychological safety is really above all about how teams work with each other, and in particular whether a team encourages people to speak up, to challenge, to try to improve what's going on. Or whether anything that dissents or challenges or suggests that things aren't quite right is something that's suppressed by that time. So in some ways it has a lot in common with organisational notions of openness. And I think what's distinctive about psychological safety is that it's particularly thought about at the team level. So sometimes you can have an organisation that says lots of good things about openness. But when you get down to the level of the team there's key people within it, perhaps senior people, perhaps the team leaders who really don't reflect that in practice at all.

And of course if you're in a team like that where the culture is not to speak up, the culture is to keep your head down and hope you don't get noticed, because if you do get noticed you're going to get picked up for it and you're going to get mocked for it or even punished for it.

CM: I think one of the things that I found really interesting when I first was reading about psychological safety and obviously you can't talk about psychological safety without talking about Amy Edmondson, was the idea that when she looked at teams where they were reporting lots and lots of errors, those were actually the most psychologically safe teams. Which I think too many people might seem paradoxical in that you think well, why are they making loads of errors? Well, they're not. They just feel able to report them and learn from them.

I think going back to your idea of blame, I think obviously doctors, when we think about blame we think about the GMC and court hearings and inquests and getting our professional licenses taken away. And I think that that's probably quite an archaic understanding of blame. In terms of research and the way that you guys look at blame, from a health research point of view, is that always as negative as we present it to ourselves?

GM: I think what you've said there captures it quite well actually. It's certainly the most visible or most prominent part of blame. Sometimes, it doesn't happen that often, but sometimes you are in a situation where doctors or other healthcare professionals are hauled up in front of their professional regulator. Sometimes they're struck off and sometimes they're even criminally prosecuted. And I think that's one of the biggest fears, well, you've just said it, that sticks in the mind of healthcare practitioners in terms of the risks of practice in general and the possibility of getting blamed for something that's happening.

I think a lot of blame goes on below the surface as well. So it's not just those really big events that hopefully in the course of a career you will very rarely if at all have to encounter. It's also much more prosaic things in terms of relationships within teams. So it comes back to the point about psychological safety. If people are fearful that the moment that they raise a concern about something, either they themselves or a colleague is going to get blamed for it and they're much less likely to speak up about that. And therefore the team and the rest of the organisation is much less likely to learn about it.

So it manifests at these various levels. It's not just about the really, really big ticket things. It's also much more about the day-to-day things and we shouldn't underestimate the impact of those, particularly for people who are junior on their day-to-day lives and their careers and all the rest of it. So blame has that chilling effect or can have that kind of chilling effect on what people are prepared to do. And if it is just about blame, if it is just about pinning responsibility for something that's gone wrong on the most obvious person, the most obvious candidate to take the blame for that, then not only is that very bad for the individual, it's not good for the organisation either, because it's very rare that something is really that simple, particularly in healthcare.

These are complex organisations and usually there is something underlying, there are systems that could be made better that could've

helped that person not to make the mistake in the first place. So I blame is unhelpful, if it's all you're looking for because it means you're not looking below the surface, beyond those superficial immediate problems to what the later conditions are that allow that active failure to take place.

CM: So I think this is probably going to be a good point to go to our first interview with Jo Wright. Jo's a midwife who's been practically applying some of these principles for years and has some really great advice on how to implement them. That'll be coming up after this from our sponsor.

S: [Advertisement]

CM: Now, back to my interview with Jo.

JW: So my name is Jo Wright, I'm a Deputy Director of Midwifery, Gynaecology and Sexual Health in the West Midlands, at Walsall Manor Hospital. Previous to that I've been in maternity services now for 22 years. So previously I was a consultant midwife for six years, and that looks at research, audit, clinical practice, leadership type roles. Prior to that I was a matron on a delivery suite as well for six years, and prior to that I was a delivery suite sister for a number of years. And I had a short period as a nurse in gynaecology as well. And at the moment I'm in maternity and loving it.

CM: That's amazing, you've lived 1000 lives.

JW: Well, do you know, I actually… When I left my job as a delivery suite sister I did ask the question how many babies had I delivered? I asked them to pull the data out for me. And they told me I'd delivered 1000 babies, and that was in 2011. So I don't know what's happened since then. I didn't ask, I'm not asking anymore. [laughter]

CM: Lost track of the numbers after that.

JW: Yeah.

CM: I'm really glad that we've managed to have a chat with you today. One of the things we've been talking about on this episode is psychological safety, blame culture, just culture. I think in recent years obviously there's been a huge spotlight shone on maternity services, not always for good reasons unfortunately. And I think I'm really interested to hear your view on how you create a department, a unit, a team where you can call…I suppose call out problems, but without creating this really toxic culture of blame and finger pointing.

JW: So this is something that I've thought a lot about. When you've acknowledged that something's gone wrong the immediate thing is why did that something go wrong? And the easy thing to do is to say that well, that person was there, they did it, so that's why it went wrong. So that is your classic blame culture.

We've got to think about break it down, what does blame culture do to an individual and an organisation? Blame culture for an individual is devastating, whether you did something or you didn't, and by that I mean whether you were at fault or not. And you are blamed, the reaction is going to be the same for you in that you have to start…you start questioning yourself. The fear factor cannot be underestimated when you are blamed for something.

It will affect the way that you practice after that. You are probably more likely to make a mistake because you're so frightened of making a mistake. You'll make a mistake. You feel that everybody is talking about you. You feel everybody is watching you. You feel whispering campaigns are happening about you. So that's what happens to the individual.

Then when you look at what happens to the organisation, if I see my colleague being treated in a certain way when they are being blamed for something, that's going to make me retract a little bit. That might make me not speak up as much as I did before. That might make me become quite defensive in my practice as well. So what's the end result of that? The end result of the individual in the organisation is how is that woman at the end of it in maternity services…I'm using the example of maternity services, how is that woman going to be treated at the end of it?

So again, which is where our defensiveness might come in, in that we over treat, because we're concerned that if we don't over treat and something happens we're going to get the blame. We under treat because we're frightened of doing something that might cause a problem. We might speak to the woman in a certain way, very paternalistic, very authoritarian because you want her to do what you want her to do, and then therefore you diminish the choice elements of what she may receive. So as you can see, the individual, the organisation, the woman, are affected by blame.

Something that we need to be very mindful of when we're looking at how people are treated following an incident or a concern is how professional groups react again. So I'll give the example of if we look at the concerns that happened in maternity services recently, I'm not going to say the names of the hospitals, because sometimes that in itself, hearing your hospital spoken about all the time can be very upsetting. So I won't name hospitals here. So several maternity units that have come to the attention of the national media.

And within that media there's very much a focus on midwives. And what does that do to an organisation? It can make the organisation feel that it is a problem with just midwives or one professional group. Whereas it cannot be an issue with one professional group. So you might get individual professional groups separating and retreating from each other because they do not want to be associated with the blame, with the negative press around that group.

In a good organisation what you find is professional groups will come together. And by a good organisation I mean a good culture. Those groups will come together and they will work together, and they will support each other. In organisations where the culture is probably not as robust as we would like you'll get retreating. You'll get people not wanting to be involved.

We've been looking at a lot of ways how we can resolve that initial feeling of blame and try and remove that. I know within organisations that I've worked in we've been striving, and I'll definitely say in the last few years to have a more just culture. So that people feel that what am I judging my concern and error and incident on? There needs to be transparency in how I am being judged by what I have done. And a just culture provides that because it provide a framework for people to actually look at what has happened.

So I'll give an example. Say there was a poor outcome for a neonate on the delivery suite. Within a just culture framework we would look and say was that a mistake? Was a mistake made? If it was a simple mistake, yes, it's still a poor outcome, but it wasn't deliberate intentional harm. Then we'd probably look at well, okay, so it wasn't quite a mistake but that person didn't follow a guideline or a policy. So there's some kind of accountability there but we have to find out why didn't you follow that guideline or policy? Was it easier not to do so? Was it that you were doing your nice workaround that made your working life a lot easier, then therefore we need to look at our processes. So that's the second tier. So again, I'm looking at you and I'm thinking why have you done what you have done?

So my third level is you are just reckless. And you did something that you should never have done. You knew it was dangerous. I'm going to treat you completely differently than I'm going to treat somebody who's made a mistake. And this is where I think we need to get the balance right and use a just culture, because that will remove the fear factor. And once you've removed the fear factor around the concern and an incident you will get truth. And until you get truth you cannot get change. So that is one of the most important things.

CM: Picking up on the other thing that you said about when you have a poor outcome to something goes wrong, I don't know, I think I've definitely seen it in my practice where something's gone wrong and there's this almost need to segregate people into groups. Like well, us doctors did this and you nurses did this and the midwives said X, Y and Z. And I think we've all seen…probably got examples on varying levels of how damaging that can be in terms of team working, because you cannot work as one group of professional individuals.

What kind of strategies do you think that we can implement, either as individuals or within departments to make sure that that doesn't happen when things go wrong?

JW: So within my current trust now, I joined this trust about three, four months ago, and I saw it in my last trust, where something goes wrong or if there's a concern or anything like that, we try to move away from statements. The statement writing culture. You actually need to get the people who are involved in a room together. So they can talk about actually what happened.

I don't want I did this and I don't want a piece of paper that said I did this and then I did this. I want to hear in a room oh, Jo, do you remember you went and picked this up? Because I asked you to, and then I did this because you did that and then this is why this happened. So when we're looking at things we need content, we need context. We don't get context really from a piece of paper. A written piece of paper in front of you in form of a statement. You get context when you get people, what we call the roundtables, following anything that's happened. You get the context of actually what happened and why it happened. And we involve everybody in that roundtable.

Because I can tell you an example, we had a really quite poor incident that happened on the ward. This was a few years ago in my last trust. And everybody was saying this and this and this happened. And it was the housekeeper who saw what really happened. And she was able to tell us what had happened and if she hadn't have been there, and then everybody else then fell in and said yeah, because she was lying like this. And I couldn't understand why she was like that. But it just brought it altogether.

CM: Reflecting on that interview the thing that I've gone back to time and time again is Jo's point about the difference between the effect on the individual but also the effect on the organisation of blame. So she talks about effect on individuals, you end up over or under treating people. But I think one of the concepts I'd never really considered before is how you might become more paternalistic with your patients. And she uses the example of you need to do this, because if you don't, X, Y, Z. And being very didactic in the way that you tell patients what you do. Which I thought was quite interesting.

Is that something that you see maybe even within healthcare organisations but other organisations as well where people change their individual practice and the way that they are with their patients when there is a blame culture existing?

GM: Yeah, I thought that the points that the Jo made about defensiveness were really, really interesting and why she made clear there was that none of this is something that improves practice. It's actually going to make practice worse, whether that's under treatment, over treatment, paternalistic attitudes towards patients, less willingness to voice concerns, to try to gain improvements or whatever else. And I think that's exactly what we see when a culture focuses on blame alone.

CM: Jo mentioned just culture. Now my immediate thought was just culture, is that just the same as no blame culture? Maybe it would be helpful if you

could explain if they're the same thing or if they're different and how they're different?

GM: Yeah, I think they're subtly different. And in a way just culture is perhaps an evolution of the idea of no blame culture. So no blame culture was certainly something that was talked about as a response to blame culture. And particularly a response to all the problems that we've already talked about that are associated with blame culture. But no blame culture has got a lot going for it because it does try to refocus on the system.

But there have been criticisms of a no blame culture as well. Not least because actually in a complex organisation like healthcare, yeah, sure, the practitioner isn't the only person who's involved here. The doctor isn't responsible for everything that goes on. But they do play a really important part in it. And actually for a good well-functioning healthcare system we need to have doctors and nurses who are professional, who are on top of their game. Of course they're going to make mistakes every now and again. They are human, everyone makes mistakes. But on the other hand, if we simply say it's the system that wants to blame almost, then we're missing a really important part of healthcare.

So the idea of just culture shifts the focus a little bit away. So it doesn't say that blame is always inappropriate. It probably wouldn't use the terminology of blame. But it would use the terminology of accountability. And what it would emphasise in particular is that there are acts that are not blameworthy, because simply someone was the victim of circumstance. There are acts that are blameworthy. In an extreme sense it might be where someone is operating with malign intent. Or it might just be that someone is operating slightly negligently, operating outside their competence or refusing to take onboard training or whatever else.

Of course there's lots of continuum between that and really to put a just culture effectively into practice you need to be attuned to all of that grey area. And I think that was what Jo was getting at with some of what she was discussing about the kinds of questions she asks of her colleagues when things have gone wrong.

So what a just culture would say is absolutely, yeah, you need to account for the situation, you need to account for the circumstances. Were there extra pressures that day? How well was the individual who was involved in the incident being supported? Were they on their own? Were they being let down by colleagues? Was there something about the situation that was something they simply couldn't expect? Had they been appropriately trained? So we take all of those things into account but it would also take into account the fact that we should expect high standards of healthcare professionals and based on all of those facts, it would try to come up with a response that was appropriate to the situation.

Really, really difficult of course to set up prescriptions for how a process like that would go, because every case is going to be different. So it's

difficult to put into practice, but that's the kind of basis of the idea of a just culture.

CM: I think, yeah, that really makes sense to me. I think sometimes as a trainee you can sometimes look around and think is it just look when people get held accountable for things? But I think that idea of justness and responsibility is obviously really important. And again, going back to Jo's point about how she always asks why, so okay, yeah, there are those people that are a bit sloppy, maybe cutting corners. Why are they doing that? Is it because they're bad doctors or is it because the guideline there is making their job harder and they don't see the purpose of it?

GM: That's exactly right. I mean I think you've hit the nail on the head there really in talking about luck and what a just culture would try to do is just perhaps start to take some of that arbitrariness that can characterise a blame culture out of it. So it becomes less a matter of that person was in the wrong place at the wrong time and more a matter of taking real account of what was going on in that place and at that time.

So just culture is partly about the process, about operating in a way that is justifiable, that accounts for all of these things. The other key part of a just culture which is less about what you do when something goes wrong and much more about what you do to try to create a situation where things are less likely to go wrong, the other part of it is that it attends to those organisational responsibilities.

So if you're working in a functioning organisation where there are good systems and processes that help you as a healthcare professional rather than hindering you, where the standard operating procedures, the pathways, the protocols, et cetera, are easy to understand, they make sense, they don't incentivise you to cut corners, to try to get through the workload. The workload is manageable, the support is in place, all of those kinds of things. Then that's an organisation that's doing what it can to support you. And actually that's an organisation in which a just culture is much more possible because if those things are in place then when things go wrong of course they're investigated appropriately and all of those contextual factors are taken into account. But if you can say the organisation has at least done what it can to make it easier for you as a doctor or a nurse or any other healthcare professional to do the right thing, then blame becomes less arbitrary. And it's still possible, but people do things and they didn't have any responsibility for them whatsoever.

But actually there's some kind of… You can see the logic behind accountability in a situation like that, because at least the organisation has done what it can to support you, rather than just dropping you in the deep end and saying oh sorry, that was your fault, when someone is harmed.

CM: I think listening to you talk about that makes me think a lot about the Datix system that we use in the UK. And I've thought a huge amount about this because how do you create a system where we can report errors or

mistakes that are made, hold people accountable and responsible, but also examine the system problems that allow those errors to exist. And I do sometimes think, Datix often gets used as a threat. It gets used to generate fear within clinicians. If you don't do this I'll Datix you or oh, we should Datix this. Oh no, please don't do that, because if you do that someone's going to tell me off. It's that kind of culture.

GM: So I think most healthcare organisations are going to have parts of them are going to have times when it feels a little bit like that. Probably what distinguishes healthcare organisations that have a most positive culture and perhaps a more just culture is that there's at least plenty of encouragement to view Datix instance reporting, all of these kinds of tools, not as a means of punishment but as a means of learning. Which as I say, is true to the original intention.

Easier said than done, and the thing is that it's going to vary even within a healthcare organisation, let alone between them. But it comes down to the standards and the expectations set by organisational leadership. It also comes down to how people use that tool in practice. And you will find sometimes people report themselves, in inverted commas, or use Datix to report instances where they were centrally involved in, and essentially role modelling that behaviour that this is about learning. That something's gone wrong here, I'm not saying that I'm necessarily to blame, I may well not be to blame, but this is worth trying to get to the bottom of. This is worth investigating. This is worth learning from.

GM: I think the other thing that Jo talked about that's really stuck with me is the way that she has started to approach incident investigation in her trust. So the incident is reported, okay, so let's say a series untoward incident and they're going to start investigating it. In every organisation or every team that I've worked in, any hospital that I've worked in, if a SUI, serious untoward incident is reported everybody is encouraged to go away and write a very legally worded letter that inevitably ends up being very defensive.

I think Jo's example of getting everybody in a room and talking things through to really work out what happened, and going back to the concept of voice that Mary Dixon-Woods talks about, I thought that that was incredibly powerful. And instead of everybody defending themselves it's let's all actually get to the bottom of what happened. Have you seen any examples of this or any evidence of where that sort of approach has really worked?

GM: Yeah, I thought that was really fascinating for a number of reasons and one is, like you say, once it gets down to statements then it becomes a matter of he said, she said, and it's accountability is large in what's written down. And the moment that people commit things to paper, of course they may well be trying to be truthful, but they're very conscious of how things on that paper might be used in the future. I think the other thing that was really interesting there was that quite often people's recollections genuinely will

differ, and actually it takes more than one person, it takes all the people who are in the room at the time of it to make sense of it collectively. So there's something about that dialogue actually that is really important to get to the bottom of what happened.

I think the challenges of doing that kind of thing regularly are several. So for one thing it's obviously very time consuming, it takes real commitment, leadership and wanting to make the most of these incidents to improve quality and safety, to achieve that. Two, is there are institutional expectations, which apply to at least some untoward incidents around what an investigation should look like. The time scale during which it should take place, who needs to be notified, including patients and families who might well have a responsible expectation to be notified and also other bodies, be they inspectors or commissioners or whatever else.

So quite often there is a need to fulfil certain institutional expectations about how you go about an incident investigation. But even if you've got to follow through with those procedures, even if you've got to have a report that is filed for accountability at the end of it, there's nothing to stop you from pursuing parallels approaches like that. And that of course may not just involve the clinicians involved, it may well involve patients and families as well because they will have perspectives. They have a legitimate stake in understanding what was going on. And certainly that kind of forum, I hesitate to say safe space, because that has certain legal connotations. But a space in which there is clear understanding about the purpose of it. There's clear understanding that this is primarily about learning, not about blame. Okay, accountability can't be got rid of completely, and as we've said it shouldn't necessarily be gotten rid of completely.

But if you can set up those kinds of expectations then you can have very, very different conversations that can be much, much more productive, particularly for improving and trying to prevent similar occurrences in the future.

CM: I'm really glad that you brought up patients and families, because their voice is so important. So I think on that note I want to introduce Susanna Stanford who I had the pleasure of interviewing, who is a patient and expert by experience. So we'll have a listen to my interview with Susanna.

SS: So I'm Susanna Stanford. In 2010 I had experience as a patient having a C-section for my second son. Unfortunately the spinal anaesthetic failed, which was very traumatic. It wasn't a failure of technical skills and subsequently I became really interested in non-technical skills and human factors. And also because of my experience working to achieve learning, which isn't straightforward, I became very interested in the system and cultural factors which get in the way of achieving that.

Within the actual procedure and the operation I was…the point where I had difficulty was the testing of the block. It was not clear to me that it was working. I would say that when you're lying flat on an operating table that is

the ultimate experience of an authority gradient. You have placed yourself in the care of people looking after you, you have to trust them. Because you can't…you wouldn't be there otherwise.

So you've handed yourself over at such a huge level, that it's actually really difficult to voice concerns. And particularly if you have someone who rightly is giving the impression of confidence that something's working, they have the expertise, the skills, the knowledge and you don't. So that's a very, very tough situation in which to speak up. And if you are then not listened to, that then becomes really problematic. And when you look at outcomes in terms of people's experience of trauma it's a really strong compounding factor if people experience not being listened to. So that's within the operation.

Afterwards, the really interesting thing was that my notes weren't correct when they went to my GP. I got a discharge note that said that I'd had a routine C-section under regional, it made no mention of the general, which would've at least been a clue to something hadn't been straightforward. So it was ten months later that I actually went to my GP and went I'm really struggling, I need to understand what happened. And she's pulled the discharge notes off and I was literally able to see it on her screen. And of course it wasn't right.

And we had a conversation and even at that point I was really, really clear that I just wanted to know what happened and I wanted if possible to give constructive feedback. And interestingly when she wrote to the hospital she put that in. So she explicitly said Susanna does not want to raise a complaint, she want to offer constructive feedback so that the same doesn't happen again. So she was really clear, I'd been clear, she'd been clear.

And yet even so that's still met with the stone wall of essentially a denial and the phrase that was used was that I had been conscious and comfortable at the time my son was born. Well obviously if I had been comfortable I wouldn't have ended up having a general.

CM: I think it's the first time I've heard someone speak with such candour about being a patient within that hierarchical system and about the vulnerability that you feel as a patient. We've talked in this episode, and you are somewhat of an expert on this, about the idea of no blame culture and psychological safety. In your mind as a patient, and an expert on this, are those two things one and the same?

JW: I hesitate to be called an expert on anything. [laughter] No blame and psychological safety have a great deal of overlap. Within no blame…so a blame culture is one where the immediate reaction is to look for someone to blame. The difference with no blame is that you're trying to look at what happened rather than who was responsible. That still saying no blame still kind of anchors it to the concept of blame, even if you're trying to talk about the absence of it. And I think it was James Reason who came up with the phrase just culture. Wherein you're developing a culture wherein trust

enables reporting to occur. And the focus is on facilitating learning to drive safety improvement, okay?

Obviously if you have an environment where it is a blame culture, that's not a psychological safe environment for people to be working in. The difference with psychological safety… So let me use some statements, okay? So in both a just culture and with psychological safety you could say if I make a mistake on this team it will not be held against me. Psychological safety goes further than that. Because with psychological safety you could say I can ask questions without looking stupid. I can ask for feedback without seeming incompetent, for example. Or you could say people on my team are able to discuss difficult issues constructively. Or you could say I do not think that anyone on my team would behave in a way which would deliberately undermine me. And that's coming quite a long way from our original concept I think.

You cannot just declare that you have psychological safety. That's not it. It has to be borne out every day in the way that people behave to everybody around them. And that's because it's about shared values.

CM: One of the things that we're really keen on in this podcast when we talk about things like this is we do a lot, and I am sure you more than anyone probably appreciate how much we do this in healthcare. This idea of admiring the problem and saying oh yes, this is a problem that happens. Oh, human factors is bad or we don't communicate, we don't listen to people.

In terms of moving forward and thinking about how we could do things better, so people listen to this podcast as junior consultants, or trainees, or even senior consultants, I mean god, I hope that are listening out there, what can we do to change this? What can we do to make this better across the board?

JW: So around this concept of psychological safety, if we take this as being really key for patient safety and clinician safety and I would be really clear that those two things are irrevocably connected. They are two sides of the same coin. You're never going to have one without the other.

I think you have to model the behaviours you want to see within teams, consultants will have a greater impact through the behaviours they demonstrate. But actually, you know what, anyone can help create psychological safety. There's a brilliant book called Fearless Organisations by Amy Edmondson. And in it she comments that sometimes all you have to do is to ask a good question. And she would define a good question as being something that is motivated by genuine curiosity or by the desire to give somebody a voice. And by using such a question you are conveying your input is important to me.

And that's not between just two people. That is observed, and it is observed by other people in the team and it is observed by patients, provided they're

conscious. But it is observed by patients. Patients are observing the behaviour all the time. Don't forget that. So you're creating space for input, you're creating space for those questions. And yet you're just setting the tone.

And the flipside of that is you've also got to be listening, really listening. And listening builds rapport, it communicates respect, and so that's part of it too. But it's really quite basic to me. It makes me laugh, because I don't think the word is actually used in the entire of Amy Edmondson's book. Because for me it's about kindness. If we want to bring the best out of the people who are around us, we need to be kind.

CM: What I really liked from what Susanna said is that hospitals can't just declare you're psychologically safe.

GM: I think what's really fundamental, and this goes back to what we were saying at the beginning, is that psychological safety is something that really manifests at a micro level, a local level, at the level of a team. And it's one of those things that you know it if you have it. And regardless of whether people say this is psychologically safe or this isn't psychologically safe, if you work in a team you will know what the informal, unwritten rules of the game are. You will know whether people are happy to speak up, to express concerns, to be informal with each other, to joke and things like that actually. Or whether interactions within a team are very formal, very hierarchical, people know again when to keep their heads down. People know what is not permitted to say.

So it comes out of all of those interactions that build up overtime and team members may come and go, but actually the spirit of the team is likely to stay quite similar, whether it encourages psychological safety and whether it encourages people to speak up with concerns, suggestions or improvements, or whether it doesn't.

It's very likely that within a team some people are going to be more influential on that psychological safety than others. So certainly a lot of responsibility does fall to leaders within a team. And if you're a junior doctor then you're not a leader yet but you're going to be a leader one. Day there's plenty to be learnt I think from a team as to what is good practice, what is good role modelling and what's not.

Having said that though, teams are more than their leaders, so there's plenty to be done regardless of your status within a team, regardless of your situation. And again, it comes back to something that I think we've heard to some extent from both interviewees that everyone has a voice and everyone's behaviour influences the behaviour of everyone else. So there are things that you can do. Susanna was talking about opening up conversations, asking the right questions. Basically encouraging conversations that bring people in.

So there's quite simple things that can be done to try and bring in people who seem to be marginalised, being attentive to each other's behaviour. Listening was another thing that Susanna really emphasised.

CM: You talk about feeling psychologically safe and that you get a feeling if your team is psychologically safe or not. And I did anthropology for a year when I was at uni, and one of the things I learnt from anthropology was that a lot of things that we feel or we know as humans, you can actually study and breakdown into rules. And that they're not always universal rules. So the example I always come back to is if someone buys you a pint when you're at the pub. You buy them a pint back, because that's gift giving culture, and in the UK gift giving culture is very central. So if someone buys you a pint at the pub and you don't buy one back, that's rude. But that culture is not universal, it doesn't exist in every society. And the measure in anthropology of those rules and those things that create that culture is ethnography.

If I was to go into let's say the NHS or indeed any healthcare setting and to do an ethnography, are there certain cultural rules that exist that create psychological safety? And can you measure that? Or is that always going to just exist as a feeling do you think?

GM: So the short answer is that you can measure things like psychological safety, things like team culture and that people have come up with instruments for doing that. So there are safety culture measures, for example, safety climate measures. And what they tend to rely on is people's perceptions of safety. So questionnaire instruments and the like. And you can use them to track progress through time and see how things are changing.

I think a lot of it, as you say, you do intuit. You get a sense of what is right to say, what is appropriate to say and what is simply frowned upon. And as you've said, ethnographic research really tries to get into that stuff that's not obvious that perhaps can be measured, but perhaps when measurement doesn't do the issue full justice, and if you're going to understand a culture with a view to changing it then you really need to get that intimate sense of what's going on, all the unwritten rules, all the unspoken rules. The things that aren't even cognitively known that are just implicit, that team members don't know that they know, even though they're reproducing them all the time.

And I think that makes me think of the other thing that really struck me from what Susanna said, which is about…which is what we ended the interview with, was it's all about kindness. And I think on the face of it initially, I don't know about your initial feeling on it's all about kindness was, but mine certainly was oh yeah, okay, that makes sense. If we were all just nicer to each other then we'd feel psychologically safe.

GM: Kindness, what's not to like about kindness? We should all be kind. And I think there's a bit of truth in that. And there's some really good campaigns basically in and around the NHS, I'm not sure if you've come across Civility

Saves Lives? Again, being civil, absolutely, we should be respectful. We should listen to each other. We should try not to rebuke each other inappropriately. We should try not to be short with each other.

I think in one of your recent episodes Mary Dixon-Woods talks about snarkyness and what a chilling effect again that that can have on things like psychological safety and whether people are happy to speak up or not.

I think where I would differ slightly from Susanna is…well, no, I suspect we'd agree on this, but I suppose what you have to be careful about when it comes to kindness is that it doesn't get too comfortable. So it'd be very easy for kindness to translate into reluctance to challenge, even deference, particularly deference between people who have different social status. So deference up that authority gradient.

So kindness is good, civility is good. But actually the real challenge I think is to combine kindness, civility, respect with robustness, and actually a consciousness of what the standards are and what we shouldn't let slip. The standard that you walk past me and the standard that you accept and all of that kind of thing. And really the trick to this, and again, this came up in the episode I think when Zoe and Mary were talking about this, is to find ways of making it possible to have those slightly difficult, slightly awkward, slightly threatening conversations. Because if you're shying away from this, it's so easy to do, but if you're shying away from those then you're not going to have a safe organisation. And actually that's not what psychological safety is either. Psychological safety is being able to confront those difficulties.

So I think it's kindness, but kindness accompanied by a willingness to challenge and a willingness really to see through your commitments, see through your obligations as a professional, even if that does mean getting into difficult conversations, uncomfortable situations at times.

CM: I really challenged… I mean I could've spoken to Bob Claybourne when I interviewed him all day about this. Because I think my understanding before I interviewed him was that kindness is the same as niceness. And I mean he challenged my perception of that and I challenged his a little bit I think. And now I think well, the kind thing to do is not just to let that person continue to be snarky at everyone, because it's not kind to patients, because the outcome is not going to be good, and it's not kind to myself and it's not kind to that person, because maybe they don't realise they're behaving like that.

And it's so much easier to stay quiet…

GM: Isn't it just, yeah,

CM: So much easier to stay quiet.

GM: And of course once you've stayed quiet once it becomes all the harder not to be quiet the next time. If you've tolerated something that wasn't quite right the first time, then what's so different about the second time? And that's…again, it goes back to concepts you've explored in past episodes, that is how problematic cultures become normalised, how they produce themselves. So actually, yeah, you owe it to yourself. You owe it to the people around you, and above all, you owe it to patients, to take those chances, to take those psychological risks and a psychologically safe environment will make that just a little bit easier.

CM: I think that's a good point to wrap up on. Thank you very much to Graham for joining us. We're looking forward to having you back again soon. I also want to thank our guests Susanna Stanford and Jo Wright. That's it for this episode. You can find the rest of our episodes on Apple Podcast or Spotify or all major podcast apps. While you're there please do rate and review us. I'm Clara Munroe and this is Doctor Informed. Thanks for listening.

End of transcript