CM: [Music]. Welcome to Doctor Informed, brought to you by the BMJ, and 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 involve medicine.

I'm Clara Munro. I'm a surgical registrar in the North East of England, and a freelance clinical editor at the BMJ. In this episode today, we're going to be talking about reflecting on a crisis. We've talked loads and loads in all of these episodes about how to prevent patient safety issues occurring. But sometimes situations are out of anyone's control, like COVID, and so what do we do afterwards? To reflect on that reflection, I'm joined again by Graham Martin. Graham, welcome back to Doctor Informed. Can I get you to introduce yourself?

GM: Thanks, Clara. Good to be with you again. Yeah, my name's Graham Martin. I'm Director of Research at The Healthcare Improvement Studies Institute at the University of Cambridge, THIS Institute, and I've got an issue in all the things you've just talked about, all of the things that make doctors and others work well which go beyond those technical skills.

CM: You've got skin in the game at making things better, as much as we all have [laugh]. I'm sure you've had lots of time [laugh] to think about this, Graham, especially since we've had one of the biggest health crises in probably all of our lives, in the form of COVID. Have you seen anything in your work, particularly around COVID, that you think would be useful for clinicians to know about?

GM: I mean, I think there's going to be lots of learning, and not all of it is going to be obvious straight away, and that applies at various levels. Of course, we've just this last week, at the time of recording, had the launch of the national COVID inquiry, which I think is really, really important. Undoubtedly, there'll be lots of important stuff coming out of that, and not all of it will be easy to hear.

I think it's important to emphasise the uniqueness of the situation. This is…it's an overused word, but this is genuinely unprecedented, and we hope that something quite like it won't be happening again any time soon. But I think there's also plenty of it that we can learn from those extremes that will hopefully help us to do better in our more regular work, and we'll hear a bit about some of that today.

CM: Yeah, I think it's really interesting that you talk about the extremes, and you talk about learning, and you've mentioned the inquiry. Do you think, in your experience, that clinicians are good at holding mirrors up to themselves?

GM: I think it's a good question. I don't think they're atypically bad at it. I think…

CM: [Laugh].

GM: …everyone finds it [laugh] challenging. It's not the easiest thing to do. I mean, again, we've talked at various points about how the medical profession itself is changing as other professions are. I think that's probably a reasonable accusation you could hold up to earlier generations of doctors, to some extent, and earlier generations of other groups, but a lot is changing in that regard.

I mean, we do know that that kind of failure to reflect, failure to accept that we're not perfect, failure to see the things that we could have done better, has been implicated in big healthcare problems in the past. The one that comes immediately to mind is paediatric cardiac surgery at the Bristol Royal Infirmary, where the data was there, and had been there for some time, to show people that things weren't quite right. If the people that mattered had looked at it and acted on it, then a lot of…well, deaths in that case, as well as other suffering, could have been averted.

So there's certainly challenges around learning, but the value of reflection is undoubtedly really important if we're going to improve. I think doctors, like everyone else, will struggle to hold the mirror [laugh] up to themselves, look at themselves, and see their defects and imperfections in a true light. I don't think that's an exception for doctors, but it's really, really important in healthcare because the stakes are often so much higher than in other walks of life.

CM: I think it's interesting that you mentioned data and data points there because I think one of the common themes that have come through some of these episodes that we've been recording are…I guess are about how we measure patient safety.

GM: We don't [laugh] suffer from a shortage of data. There's loads of data out there – some of it is more useful than others – and actually the challenge a lot of the time is processing that. I saw some interesting research recently that was looking at the dashboards that boards of healthcare organisations use and… Well, when we think of dashboards, at least in kind of the original sense of the term, we think of something that's in front of us [laugh], like a car. We've got, like, perhaps two things that are standing out at us, the speed that we're going out and perhaps the revs, perhaps the time of day, something like that. But it's a minimum amount of information. It's the most important information to tell us what to do. The dashboards that boards often end up looking at are enormous documents with loads and loads of data over many, many pages, and they're really not dashboards anymore.

Now, of course, it's challenging because probably if you looked at those things one by one, you'd say all of them matter, but the more [laugh] you have there, the more difficult it becomes to see the wood for the trees and to turn that into useful information and useful action. Again, we do see examples in the past of that where almost it's the information overload, the surfeit of priorities, expectations and measures that stop us from acting proactively.

To come back to your question and answer it a little bit more directly. I think data is absolutely crucial in this. But inside, by which I mean some of the wisdom, and probably the time actually to be able to make sense of those data and prise them apart to see what's most important, discuss them, reflect on them, are also important.

CM: So that segues really nicely into our first interview with Annelieke Driessen. So Annelieke is an anthropologist who collected qualitative data on patient experiences on intensive care during the COVID crisis. I think an important warning before we listen to this first interview is, I found it, as a clinician who worked during COVID, really difficult to listen to, and I think most clinicians when they listen too may understand why. Obviously this data absolutely was not collected to ostracise clinicians. It was used fundamentally as a learning point. So I think…yeah, I think this was a really unique experience that Annelieke had to interview these patients. I think things that we can learn as clinicians, although difficult to hear, are really important.

So, Annelieke, it's lovely to meet you, and it's such a pleasure to have you on the podcast, Doctor Informed, today. Would you like to start by introducing yourself and a little bit about what you do to our listeners?

AD: Yeah, thank you so much for having me. I'm really thrilled to be here. So, yeah, I trained as a medical anthropologist. I'm working at the London School of Hygiene & Tropical Medicine, and I'm also a fellow at The Healthcare Improvement Studies Institute, which is called THIS Institute. We're also the funders of this project that I've been doing. Yeah, I'm very, very interested in life at the margins. I've previously done research on dementia and palliative care, and recently on intensive care and how patient experiences and subjectivities come to shape care interactions and vice versa. So that's just one of my passions.

So I've been doing this project together with Lisa Hinton, who herself has done lots of work in intensive care. For this research, I've interviewed patients and family members of patients who've been in intensive care with COVID, primarily during the first and second wave in the UK. The study is part of a larger set of studies, which is called the healthtalk studies. Healthtalk really is an online resource based on qualitative research on particular conditions organised in a number of themes.

So this is what I've been doing in the past two years to really analyse those interviews. Conduct them, analyse them, and to bring out these main themes that come up through them, to compliment all this clinical knowledge with patient knowledge. So what's it like to live through a condition, to receive treatment, to live with a condition, and to really make that knowledge available for others to learn from.

It's almost kind of awkward for me to speak about the patient experience, and therefore I think it would be really wonderful if we could listen to parts of these interviews that I've brought along. The first clip I've brought today

is from Emma, who's 41, and she works as a ward clerk in an A&E department. She and her husband have two children, and Emma spent 12 days in ICU in late December 2020 after contracting COVID.

E: I'd have killed for a cuddle. Anyone. Just I would've killed for a cuddle. For just someone to put their hand on you and just sort of go, you're alright, darling, like that nurse did. I think it might even have been that night actually. She just came in, and I cried, and she just held my hand. Oh, it was amazing.

AD: Yeah, so what I think this story really shows is this fear of proximity that was very prevalent in the first wave, against the background, of course, of not knowing what we were up against. What this virus was, how it transmitted, the degree of contagiousness, and that real sense of, yeah, peril, I suppose, that those patients were in. Patients were dying and staff really didn't know whether they would take it home to their family members. So I think against this background we can completely understand that clinicians were afraid to get close to patients. At the same time, for patients, that meant that there was very little, if any, sort of physical touch. If there was any, that would have been with gloves. This PPE, the personal protective equipment, was a protective measure, but at the same time, also very much a barrier for communication and physical contact. So the two sides of the coin.

As a result of this, as Emma illustrates in this clip, is just that there was this extreme sense of isolation. So this was the first wave, but perhaps even more so in the second wave when less patients were kind of being ventilated. More patients were on non-invasive ventilation, and they were therefore aware of what was happening around them. They could see fellow patients in the bays and when they were dying. Even though the curtains were drawn around them, would know what was going on and try to make sense of that. Many patients I've spoken to sort of describe trying to make sense of where they were at and what their chances were in relation to all those other patients around them who had the same condition.

CM: Do you think that there's lessons from your work that we can take forward for these circumstances should they happen again in terms of patient knowledge?

AD: Yeah, perhaps I'll just move to the next clip, and then we can talk about…

CM: Yeah, sure.

AD: Yeah? The last clip I brought is from Kate. Kate is a 42-year-old midwife and researcher. Both Kate and her husband contracted COVID in April 2020, but whilst she recovered quite quickly, he had to be admitted to intensive care.

K: ITU were brilliant, I have to say. If they couldn't speak to me, they would give me very clear parameters in terms of what to expect. So I will call you at…, and the reason I'm calling you for that is because I've got a drug round,

or I need to go and do this or whatever, which was great. Then they went above and beyond because I would then get phone calls from… I mean, that nurse, I need to find that nurse. I have to have that conversation with that nurse because he needs to understand the effect he had and the difference he made just by making that phone call and having that conversation as a human. So I'll find him at some point.

The wards were an absolute different kettle of fish. I was just…[sigh]. And again, there was this conflict for me because I know what it's like being on a busy ward and having to deal with patients, families, and it certainly would have changed. If I was still clinical, it certainly would have changed the way that I approach families. So I just wanted to speak to… The nurses were fine, but I needed to speak to a doctor so that I could have that conversation. I think it would have been better if they'd have said…had done the same thing, this is when I can speak to you, or this is the reason why. But they didn't. It was the, okay, we'll ring you then, and they didn't.

The biggest issue was that they didn't contact me when he'd deteriorated. I sat in my house with my children, thinking everything was fine, and it wasn't. So I lost all trust in them because I thought, if he dies, they're not going to call me. That was really hard. I think what that did is that then stepped up the number of times I was calling. I thought, right, I'm going to ring regularly now because I need to know what's going on.

AD: Yeah, so you asked about what we might learn, and I think this is actually an interesting piece of this interview just because it just also points out to the logic of why people were calling. So from the clinical side, I think we can completely empathise that it was impossible to deal with all the phone calls, right? And it depended very much on how big the hospital was, what kind of staff was available to do the family liaise, and there were huge differences between hospitals. So that wasn't because nobody was trying [laugh], but precisely because there were such different conditions of possibility for making those phone calls. But I think Kate just really nicely explained, you know, that when she felt absolutely uninformed and didn't know what was going on, that she then called more frequently.

CM: So obviously you did much more listening to patients who experienced ICU during COVID, and that's all available on healthtalk online. But what I wondered is how the listening that you did contrast to the listening that a doctor does when talking to patients. Do you think that doctors are good listeners?

AD: Ooh [laugh], is this a trick question?

CM: No [laugh].

AD: [Laugh]. I have to say that I find it an immense privilege to have time to listen to people, and I think that's one of the key ingredients, isn't it? So throughout the pandemic, I've sat in my living room, and this is what I've been doing. I've been…

CM: [Laugh].

AD: …[laugh] and clearly that's not what doctors have been doing [laugh] at the same time. So some of these interviews were three hours' long, some of them were two hours' long. Most of them were longer than two hours' actually. I think that allowed me to really sink into a bit of a comfortable conversation with most of the people I was speaking to. Yeah, so then a patient talked through this, what they recalled from ICU, onto the experience of the ward, and after that, recovery.

Actually we worked with an advisory panel for this research, a set of amazing doctors, nurses, physiotherapists, other allied healthcare professionals, family members, and patients who've advised us throughout this research. One of the doctors remarked when we started sharing the first findings, he said how little of it actually was intensive care. That really stuck with me because obviously if you're an intensive care doctor, that's the part you see, and you might be involved in a bit of the follow-up. But that whole phase of leading up to it and leading out of the ICU, that's really something that stays quite obscure to them.

So that is my other position as a listener [laugh], as you call it, a professional listener – I like that – was really that I got the luxury of hearing that whole story. Also, perhaps sort of almost a methodological benefit that I had the time to listen to the whole story. Whereas people would have been surrounded by people who knew bits of the story, and therefore there's never this occasion to share the whole story.

CM: So I'm a clinician, and I'm hearing what you're saying, and I hope that everyone who listens to this podcast will as well. But I'm interested. Have you spoken to other clinicians about it, and what's their response been?

AD: Absolutely. So we've worked with clinicians, both in the advisory panel that we've had support us and advise us during the course of the study. What was always a good result for me was when they said, okay, we really recognise this, this is something that reflects what we've seen in our patients. I think what this work can do is, first and foremost, an acknowledgement of the very difficult conditions under which cared-for patients with COVID was provided and how incredibly difficult it has been for patients, for family members, and for staff.

I think that's one of the key learnings for me, that they're so related, these experiences. So much of this moral injury and pain is shared across these three roles. So actually in the advisory panel meetings, that always haunted [laugh] me a bit, you know, where so much of it was felt almost…not in the same way, of course. You know, it's very different to be a doctor working in ICU and being a patient in ICU, but very much that there was this empathy and understanding on both sides.

The other thing is, of course, to add things to the conversation that wasn't familiar to doctors because otherwise, you know, we'd just be reproducing what people already know. Yeah, I think to bring some of these issues to the foreground that weren't necessarily obvious to clinicians, I think, is the other job of this research. So one example, for instance, was that when hospitals asked family members to choose one person to be the dedicated contact person for updates that they got by the phone, family members find it really difficult to choose one person. Often it couldn't be the person most close to the person in hospital because that was emotionally really draining and exhausting. Some people wanted that position, that role, but at the same time, it was very hard for them.

So a mixture of recognition, familiarity, something novel, and the…yeah, that had previously been unknown, I think, is how I see the task of this research. [Music]

CM: So, Graham, I've alluded to my initial reaction to these interviews. I'm really interested, as somebody who works in healthcare but isn't specifically a clinician, what was your reflection on listening to this?

GM: Yeah, it's interesting. I mean, it didn't affect me in the same way, and I don't know why that is exactly. I think it comes down to, as you say, your direct visceral experience of it. So I've heard stories like that before, and I've seen the horror, but that's always been from a distance. I think your response to it, as you said in your introduction to the interviews, is probably likely to be typical of a lot of clinicians' responses because they were there. It brings back those memories, frankly, of the challenges, of the personal anxiety and fear, and also that sense that you couldn't actually provide the service to patients that you really, really wanted to. So, I mean, in some ways, what you're describing matches exactly onto what has often been called moral injury.

CM: It brought back a lot of memories. I think I felt very defensive when I listened to those interviews because I thought, I know this, I know that those patients wanted physical contact, I know that they wanted me to be human. I just remember thinking, this feels really inhumane. I think it taps into exactly that sort of moral injury thing that you talk about, that clinicians know what they want to do and what patients need from them, but you feel like because of your needing to serve the greater good, that you're prevented from doing that. It's that frustration that's really like, aargh, and I'd sort of forgotten about it. I hadn't forgotten about it, but, you know, we don't talk about it anymore now a couple of years down the line.

GM: Yeah, but it was unique [laugh], and we keep saying that, and that's perhaps partly because we don't want to be in that same situation again, or at least not any time soon. But I suppose the more generalisable point from that is that we can all agree that good quality care is desirable. We should be doing everything we can to give good quality care. It was more extreme at the time, but I think it is transferrable to other situations, and sometimes there are tensions between different aspects of quality.

So one definition of quality – and this is Ara Darzi's definition from 2008/2009, and it's quite a good one as a starting point at least – is that quality has three components: it's clinical effectiveness, it's patient safety, and it's patient experience. Sometimes [laugh] those three things are very compatible [laugh], and hopefully most of the time they're compatible, but sometimes they're in tension with each other. Particularly if you think of your concerns back then around safety. Not just of the patient, not just of yourself, but of everyone else around you, you know, who wasn't that far away from you, who you might be putting at risk if you did the seemingly humane thing. Sometimes you've got to make judgements about how to reconcile those things, and sometimes there's going to be no perfect way of prioritising all of them.

CM: Yeah, I mean, I think you're so right. I think those experiences during COVID, they were increased in frequency and severity, to use a very clinical turn of phrase, but actually they weren't completely new. I mean, I've had times where I've thought, I just want to sit down and have a chat with this patient because I know that that's better than any medicine or surgical intervention I could do, that they just need somebody to listen to them. But actually opportunity cost to that is there's seven or eight other people waiting, and it's that time. I think that that's something that Annelieke picked up on really nicely. She was really candid about the fact that this was a piece of ethnographic research, so she had loads of time to listen to patients. I think that so much of the time, you know, it's not that we don't know that patients need time, it's just that that's a precious commodity and that has an opportunity cost as well.

GM: Yeah, of course, and that is always a tension in an environment where you have finite resources, which is any environment [laugh]. No matter how well-resourced the healthcare system is, you've got that tension. Or at least a challenge of balancing between the needs of the individual and the needs of the population, whether that's the whole population, or other people on your list, or whatever else it happens to be. Again, I think you have to be not overly harsh on yourself as a clinician, as a doctor, in terms of how you make those judgements.

CM: I think this is probably a good point to go to our next interview with Dominque Allwood, who as a clinician herself has definitely been in these situations, but also now works in quality improvement and transformation. So her insight will be really great, and that'll be coming up after this from our sponsor. [Music]

S: [Advertisement]

CM: Now, back to my interview with Dominque.

DA: I am a public health consultant by background, and at the moment, I have a portfolio career across a couple of organisations. So one is as Chief Medical Officer of UCLPartners, which is an academic health science

partnership straddling industry, NHS and healthcare, covering a population of about 5,000,000 in north west and north central London and mid and south Essex. But I also work in the NHS as well, where I'm a consultant in public health medicine, and the Deputy Director of Strategy and Improvement at Imperial College Healthcare Trust.

I think that in many places that I look at healthcare [clears throat], we have become quite industrialised. By that I mean we're processing patients, we're thinking a lot about efficiency, we hurry through things, and patients often look like they're on a conveyer belt. You see them in a blur, moving. That's not why we came into medicine, and it's definitely not why patients come to us. They want help, they want care, they want connection, and they're often in their most difficult kind of periods of their life. So there's this mismatch between what I guess the system is pushing us in to do because of austerity, constraints, resource, et cetera, and what we can do. We have to do more with less versus the reason that many of us went into healthcare versus our patient expectations. I guess that kind of triangle is feeling really fractured. I guess that disconnect between everyone's expectations and the reality of what's going on is where it feels like it's the hardest work to do, to go to work and feel like you're not doing what you wanted to do.

I think the stuff about guidelines and protocols and checklists is a really good point. So I've been on the end of kind of translating a lot of that stuff that came from the patient safety world around surgical checklists and trying to standardise care. I do think that variation is often unhelpful. You don't want clinicians just going off and doing things that they feel like doing when they don't realise there's either an evidence base out there or that other people are doing something different for a good reason. So having standardisation in healthcare is important in many places. But when you take that so far that everything is guideline and protocol-driven to try and protect resource or time, you can lose those core parts of what it is to care.

I think trying to reconnect to that purpose of care is really important. So how do we see the patient in their full high-definition? So it's not just the biology, the biography too. So, for example, imagine opening up a clinical record, and instead of seeing the blood pressure, the smoking status, the biometric data, how would it look if we saw a patient's story about their life, their loves, the things that they've done before, what they're hoping to achieve going forwards, and that set the tone for the clinical encounter? Now, that doesn't need to necessarily cost a lot of money to have that as an intervention. But there's something about how we change the culture to bring care back into the core purpose of what we're doing and recognising that people are really constrained.

So I've done some work with Victor Montori, who's an amazing clinician in the States who's working on the patient revolution. He talks about, it's an organisation trying to foster care back into healthcare. He talks about the unhurried conversation could be the biggest innovation in healthcare. I think you don't necessarily need more time overall, you know, taking time to make time. We're hearing all this stuff about continuity of care being really

important. Actually, ultimately, overall, spending some extra time at one point in a clinical pathway will actually save time later down the line.

So I can say all these things, recognising that we've got these eight-hour queues of ambulances at the door and people falling over. I recognise the context we're in around burnout and burden. But the core purpose of what people came into healthcare to do was to care, and that's why people come to us to receive care. Healthcare is the commodity in which we're working in. So I think there is something about how do we help reconnect that and think of different ways that we need to do that, recognising the constraints we have.

CM: This conversation I had with Annelieke when she was talking to me about, you know, during COVID, these patients on ICU, they felt like they lost their humanity. I think as a clinician I heard that and I was like, duh, I know, that's what I want to give more of. But when you're in the middle of that conversation, you think, I've got seven other patients to see, that can be really difficult. Can you, how do you, make that balance between fixing the very real problem right in front of you, which is the growing waiting lists and the patients?

DA: So there are always going to be urgent pressures in a constrained system that will never have enough resource to do everything at once. We are a universal healthcare system, and in many ways we provide amazing care to a huge number of people, but we can't do everything. We look at the alternatives over the pond and think, well would we rather have a system like that? I think most of us agree that we want an NHS that is a publically-funded system, but there will always be constraints.

I think there are a few things that we need to do more at the level of organisation and as individuals as well. At the individual level, having a look on your working week and thinking, are all of the things that I'm doing adding value? Is there a way in which I need to stop doing some stuff, like the workarounds, that would enable me to be able to do more of the things that will add value to patients in the organisation's care delivery? You know, if you looked across your working week, how much of the stuff do you really need to be doing and what stuff could you stop? Ultimately, even if everyone found an hour a month, imagine the amount across 1.6 million people.

CM: [Laugh].

DA: That would be amazing. Meetings that you don't need to go to, stuff that you need to stop doing, workarounds that are just a waste of time. At the level of organisations and I guess more of a system, we need to start thinking much more long-term than short-term. We will only get ourselves out of a lot of these issues if we start to do more around prevention and stopping people getting sick. So, ultimately, we're never going to magic up more resource. The politicians are fighting it out over how much we're going to have. But what we do with the resource that we have is within our gift, I

think, both at an individual level, an organisational level, and a system level, more than we think it is.

I would, I guess, be in favour of trying to have more of those conversations and more spotlight on that kind of stuff. Stopping doing things that waste people's time and doing things that we know will ultimately hold better value than the things that we're currently doing. That's choices, a lot of that, and brave decisions and culture change. But that will all take headspace. When you've got the ambulances queuing, you're not thinking about the smoking cessation. But, ultimately, we do need to think about the important, not just the urgent, in front of us.

CM: Yeah, I think that's a lesson for us all, I think. Yeah, I can't remember the last time I spoke to somebody about smoking cessation, but I will not forget it again.

DA: [Laugh].

CM: [Laugh].

DA: I've turned you into the latest champion [laugh].

CM: Yeah, well, you know [laugh].

DA: Every little helps. Every little helps.

CM: Every little helps, totally agree.

My final question is a slight gear change, I suppose, is, do you think given how bad we are as…generally, I'm speaking in very general terms, we're generally quite bad as clinicians at looking at ourselves and saying we've done a bad job here, we could have done better? We like to think that we always do a good job. We're very bad at accepting failure. I think that that is part of medical culture. Do you think we're the right people to be involved in QI and change all of the time, just because of that – sometimes – inability to look at ourselves and say, no, we could have done better, this was a bad idea?

DA: I think you've hit on a really interesting tension here. I've experienced it myself and been part of it. The way in which training happens is we're pitted against our fellow students. You're competitively ranked for stuff. So if you fail, failure is seen as the thing that will ultimately change the destination of your career. Many of us have been high-achieving through our lives, so how many people have failed at something? But until you fail, you don't learn, and you won't have humility and realise what it's like to then have an opportunity to do something different.

So I think failure and learning is a really important part of what we do, and the NHS isn't always geared to doing that. You know, we talk about issues and problems, but in a way, in the past, there's been a lot of blame attached

to that, and we're trying to move away from a blame culture now to be much more open around learning. Particularly, doctors in society are held up as having the answers to everything in terms of the healthcare stuff. People don't come to the doctor necessarily to hear that I don't know answer. They come because they want the answer. So you have to sit in this technically expert field and way with saying, well we do know, at least we know what we're going to try and do.

But I think medicine is shifting. We're much more into a space of, well what should we do together, what can we co-create here? How do we help coach patients through some of the journeys, and not have all the answers and say, ultimately we can't cure everything, we're going to do our best job, but that may not be good enough in some cases? So trying to translate that humility then into how do we think about the stuff we need to learn about and doing better in our jobs is really important. I think that's a really important part of a leader, to think about, what's it like to be on the receiving end of me, and could I personally be doing things differently and better? Are we doing the best job every day?

It's not a failure to admit that we're not. In fact, it's a kind of success to say, we want to be the best performing system, service, offer the best experiences, care and outcomes to our patients. We will only do that if we keep looking at how to try and get better. The best high-performing healthcare systems in the world have this lens of trying to learn. Now, that isn't the culture in which we've often all trained in. So how we support our clinicians to do that is part of our leadership challenge, and a lot of courses, programmes, fellowships, have started to try and help people do that. The culture is changing, as I mentioned.

The question about are clinicians best placed to lead change, I think it depends. Of course, they direct most of the resources, and they can make or break these projects. If clinicians don't engage, they can rubbish stuff and it won't happen, and it will die in a box or a ditch or a folder or a report. So when clinicians are engaged, it can make the difference, and often they are the right people to lead that and lead their colleagues. But we're seeing now patient leaders coming through who also want to support and be part of improvement and are training alongside clinicians. There are managers, manager colleagues, who equally are there to do their best job.

So sometimes it's about the right person to be the leader of that, but recognising that engaging clinicians in that change is really important. Because people, but particularly clinicians, don't want to be done to, especially when they hold a lot of the technical expertise. So how do we engage clinicians, and often that is through them being the leaders of that stuff.

I guess the worst version of that though is the not-invented-here syndrome where clinicians then take to doing QI and leading projects but they don't look elsewhere as to what they could learn from somewhere else. The power of holding a mirror up to ourselves, I don't think can be under-

estimated. But you can see how we've got to the point where people find that confronting and challenging because admitting that we're not good at stuff is really difficult.

The question about the, are we the best people to lead that, often yes, but not universally, particularly if we're not doing that with humility, curiosity, learning. We want to deliver care in multidisciplinary ways. So as long as it's something that everyone's engaged in, it's the right leader for that project sometimes. That said, we don't want to be pushing work onto patients where they're often unpaid to do that. So thinking about the right leadership at the right time, it's really important including patients in that, but not creating extra burden on them to be the leaders of these projects.

CM: [Music]. I loved interviewing Dominque. I think that she gave some fantastic, you know, not only reflections of how that time balance that we were talking about before can be really difficult as a clinician, but also [sigh], I guess, some of the ways that we can talk about that in terms of quality improvement. I'm interested in your thoughts on this as somebody who's worked in health research.

GM: Yeah, it was a really interesting interview, and I think there's so much to talk about from it. One of the points that struck me particularly strongly, particularly at the beginning of the interview, was what Dominque was saying around this kind of industrialised focus on efficiency. She clearly wasn't against that kind of move towards standardisation; she was clearly seeing its benefits as well. But it does bring its downsides. So seeing patients in a blur, as she put it, and how to get from that to moving towards seeing patients in high-definition.

I think if you look at improvement methodologies and the research evidence base around them, there's a few scores of thought on that. So we do have those kind of improvement approaches that look industrial, because actually if you look at their roots, they are from industry, from a manufacturing industry, to some extent, from service industry. So a lot of the stuff comes from engineering, things like PDSA cycles. Some if it comes from manufacturing production lines, things like Lean. Occasionally it comes from more service oriented industries. But what they have in common is that they are around trying to improve the process, particularly in terms of its efficiency, and that's good. A lot of the time, improving the efficiency can improve quality in terms of the other components of quality as well, including patient experience as we were saying earlier on.

Something like Lean thinking, for example, Dominque didn't use the word specifically, but she may well have been thinking of that approach in terms of cutting out what's wasteful and focusing on what adds value. So that's great, so to that extent, it's all very much pushing in the same direction. There are ways to improve efficiency that also ensure that you're improving humanisation because you're freeing up time to do the things that matter in terms of that relational human experience.

There's other schools of thought in improvement techniques though. So some of them come from different origins, much more humanistic thinking. So there's things like experience-based co-design, for example, which are much more about starting from the experiences of patients and of clinicians and trying to identify how to improve from that basis. Sometimes these things do lead to different outcomes. I think the key thing is trying to keep an eye on that human experience and ensure that that's not lost in the way that you improve processes.

CM: I think, like, I definitely see this a lot in secondary care, that individual bits of the system can function really well, but actually those cogs don't really work…

GM: [Laugh].

CM: …together.

GM: Yeah.

CM: I mean, I was seeing a patient in the emergency department. The patient was really unwell. I'm trying to talk to the patient, look at the obs, do other things. At the same time – and this is just probably about different vested interests – one of the bed managers kind of walked into the room when I was with this patient holding another patient sticker and said, can we fast-track this patient upstairs to the surgical assessment unit so that we can keep the flow going? They kept saying, we need to really think about flow.

GM: [Laugh].

CM: You know, immediately my back was up 'cause I was like, actually I can't concentrate on fixing one problem while you're concentrating on fixing flow. Yes, that worked for the A&E department, but then also you just put that patient in a different part of the hospital where they're another cog's problem. Reflecting on that, I was like, that is so much about that industrialisation that you talk about. You know, patients become flow, staff become workforce…

GM: [Laugh].

CM: …and actually we've [laugh] completely lost the humans within that. I wonder, are there ways of building in humanity into those industrial processes without creating that industrialisation?

GM: Yeah. So…

CM: [Laugh].

GM: …I think you've hit the nail…

CM: It's too perfect [laugh].

GM: …on the head there in terms of the challenge [laugh]. Well, it's what all of these approaches are aspiring to do but what they often fall short of doing. Sometimes because they're not focusing quite in the right place, missing out what the indirect impact on another part of the system is, sometimes because they don't involve the right people. [Laugh] going back to Dominque's point about the need to engage clinicians even if they're not leading improvement efforts. So improvement isn't easy [laugh], improvement is really hard, and good improvements tries the best it can to account for all these efforts.

I think what's really interesting about what you just said then, you know, the sort of flow, workforce, versus genuinely humanistic patient-centred care, is that it's kind of like the experience at the sharp end of that tension between populations and people. You know, you really want to give the best care to the person in front of you that you can, but you've got to remember [laugh] that there's a hundred other people out there who also need your attention. Again, it is a tension, we can't deny that, and there's got to be a trade-off there or at least a way of trying to reconcile those challenges.

I think, again, going back to Annelieke's interview, the problem, or the sort of extreme example when we don't get that right, again, is that sense of moral injury. Because you as a doctor haven't gone into medicine because you [laugh] want to make it as efficient as possible – although you might think that's a good thing – you've gone into medicine probably because you want to give the best possible care you can to the person in front of you. The system has got to manage these different pressures, but if it doesn't get it right, then the ultimate implication of that can be, yeah, moral injury for staff, for doctors, nurses, therapists, others. It can be poor experiences of care for patients.

So the challenge for improvement approaches is how to balance those competing pressures on the system without losing sight of patient experience at the end of it. Again, improvement methodologies have got a number of different answers to how you approach that. As I say, things like Lean, they may have industrial origins. But they're just as much about trying to focus on what matters to patients as they are about trying to make the system more efficient. Often that's not the way they're applied in practice though, and it can end up being all about efficiency.

There's other things. There's other improvement methodologies as well which are much more modest actually in their ambitions. The evidence base for them perhaps isn't completely clear that they transform healthcare [laugh] or revolutionise quality from patients' points of views. But things like asking what matters to a patient can be a good way of eliciting what is important to them rather than necessarily what's important to the system. The answer to that question might of course be surprising.

CM: Now, I really like that you brought up the what matters bit. I mean, I was talking to Dominque for a very long time, and we had to cut the interview so that this [laugh] podcast…

GM: [Laugh].

CM: …wasn't three hours' long.

GM: [Laugh].

CM: But one of the questions I asked her and we didn't manage to include was, in those time-short situations – and this kind of links back to Annelieke's interviews – in those situations where you have a finite amount of time but you want to do the best you can for patients, what can you ask? That what matters to you question is definitely something that I think I'm going to try and use in my practice. We were always taught at medical school [laugh] the ICE model, which is Ideas, Concerns and Expectations. I hated that because actually I was like, how do you say, like, what are your ideas, what are your concerns?

GM: [Laugh].

CM: Like, it just feels like you'd never have a conversation with a patient like that. But actually saying, what matters to you in this situation? You know, in a situation where maybe you can't just give a medicine or just do an operation that's going to fix somebody, that is probably one of the more helpful things that you can ask, given the finite resource of time.

GM: Yeah, and I think what we need to remember is that just as doctors can't cure anything for [laugh] society as a whole or for a patient, there is also the risk that intervention does more harm than good. So sometimes it may well be a matter of limiting our ambitions and avoiding doing unintentional harm.

CM: I think we're very…oh, okay, I'm going to say we're very bad. I'm quite bad.

GM: [Laugh]. Oh, I'd be worse if I was a doctor [laugh].

CM: [Laugh].

GM: It's why I'm not.

CM: [Laugh]. I mean, I think one of the things I've got better at – or hope I've got better at – is saying I don't know. Because actually I think we're always taught that we have the answers, that we have the cure, or we have a diagnosis. Actually I think just being able to say, look, I don't know what's wrong with you, I can tell you that you don't have X, Y and Z, and therefore we don't need to do A, B and C, but actually I don't know. I think that honesty is important.

I think that also leads me onto a slightly different point in the same vein, which is that we are…this was sort of encapsulated in my interview with Dominque but I'm interested in your perspective, Graham, on this. Is as doctors, I think we find it probably because of all the perfectionism and fear of failure that's built into us from the…

GM: [Laugh].

CM: …beginning, and we're almost self-selected as those people, we find it quite difficult to hold the mirror up. Are we then the right people to be involved in looking at ourselves or our response after anything has gone wrong?

GM: [Laugh] well, I think that's a really good question. I thought Dominque gave a very reflective and considered answer to the similar question you posed to her. I think there's undoubtedly something to be said for the point that you made and the point that she made about how difficult it is if you're a high achiever. You know, in inverted commas, but it's a meaningful word. You have to do very [laugh] well in school. You have to get great A-Levels to become a doctor or even to train as a doctor. Actually, the first time you fall short, the first time someone tells you off [laugh] even sometimes perhaps if you're a goody two shoes and never had so much as a detention at school…

CM: [Laugh].

GM: …[laugh] it's really, really difficult. I mean, I think there's truth in all that, but as we've said in the previous episode, we shouldn't be…whether failing is the right word or not, I'm not so sure. But we shouldn't be scared of failing. In some ways, we should greet failure, because the failure brings the learning. That's what Dominque was saying as well.

Just going back to your earlier point about how you found it difficult to say I don't know, I think that's really important as well. It's important at an individual level, as a doctor it's important if individual doctors are able to acknowledge that, and it's important for the medical profession as a whole. Just to delve very briefly into some sort of medical sociology history here. If you go back to the '60s and '70s, sociologists were very critical indeed of the medical profession because…

CM: [Laugh].

GM: …they saw it essentially as…well, looking after its own. But in particular, by expanding the scope of medicine and going into areas of society that really traditionally we wouldn't have seen as being the purview of doctors at all. But increasingly, creating medical dominance, medicalising problems that weren't really medical at their heart. Again, that goes back to this challenge that Dominque was talking about, about ensuring that we acknowledge that we can't cure everything.

So I think at a societal level, medicine, or most parts of medicine, have got much better at that, at acknowledging the limitations of medicine, acknowledging that there can be too much medicine, and accepting that not everything is a medical problem. I think what you've talked about there at the individual level is sort of the reflection of that. As individual doctors, it's important to acknowledge that you/we don't have all the answers. I suppose the corollary that goes with that is that actually it's for you as a patient to say what matters most to you because, again, I can't make everything right. So what matters to you [laugh]? What's the best outcome here? What does good look like in terms of what you want as an outcome of this healthcare encounter? Again, I've gone off on a big tangent [laugh] before coming back…

CM: No…

GM: …to answer your question. But I'll just answer it quickly. As Dominque said, I think learning from failure, learning how to improve, is a collective challenge. Undoubtedly, doctors have a role in that, and as Dominque was saying, if you leave doctors out of it, then it's only going to get worse. Because doctors have got knowledge, and they've got that sharp end view of what's really going to make things better or what might cause unintended complications that are actually going to end up making things worse. So doctors have got a place in that.

There's places for other forms of knowledge in that. Patients, carers, managers, others, they all have a view on this as well. Again, to go back to what we were talking about right at the beginning, the COVID inquiry that's just opened, that will be inviting a wide range of perspectives. Doctors undoubtedly have an important part to play in that. But it doesn't begin at them and it doesn't end at them, this is a collective endeavour. Doing improvement better means involving a very wide range of perspectives and forms of expertise. [Music]

CM: So I think you've wrapped that up really [laugh] nicely, Graham.

GM: I try [laugh].

CM: [Laugh], thank you again for joining me today.

GM: It's a pleasure. Thank you, Clara

CM: And thank you to everyone for listening. We'll be back with another episode of Doctor Informed very soon where we'll be coming full circle on this first season and have our first two guests, Mary Dixon-Woods and Bill Kirkup, talking about putting everything we've learned into practice and how to keep going in the face of continuing problems. So, subscribe on Apple Podcasts, Spotify, or wherever else you listen to your podcasts. I'm Clara Munro. Bye for now.

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