CM: Welcome to Doctor Informed, brought to you by the BMJ and made in collaboration with THIS Institute. Sponsored by Medical Protection.

Doctor Informed aims to take you beyond medical knowledge. We're talking about all of those things that you need to be a good doctor but which don't necessarily involve medicine. I'm Clara Munro, I'm a clinical editor here at the BMJ. And I'm also a general surgical registrar in the northeast of England.

So I'm really sad to say that this is our last episode of season one, and with it we're really coming full circle. I'm going to be talking again to our first two guests, Mary Dixon-Woods and Bill Kirkup, having now heard from all of the other experts over the series. We've heard loads and loads of really interesting things in this podcast series. We've talked about speaking out, teamwork and compassionate leadership, all those things that are needed to help clinicians challenge the status quo. But through all this, we've heard about the fact that the system still isn't really geared up to that as well as it could be. And there's a personal toll to challenging things.

In this episode, I'll be asking Mary how she thinks things have changed. And Bill, how he manages a career challenging a healthcare system. Firstly my conversation with Mary Dixon-Woods.

So I have the absolute pleasure of yet again being joined by Mary Dixon-Woods. Mary, do you want to introduce yourself to the listeners again for those who haven't heard of you before?

MD-W: Thank you very much, Clara, and it's an absolute pleasure to see you again. My name is Mary Dixon-Woods and I'm the director of The Healthcare Improvement Studies Institute, otherwise known as THIS Institute, at the University of Cambridge. And I have the great privilege of helping to build the evidence base for how to improve quality and safety in healthcare. THIS Institute is supported by the Health Foundation, so we're a completely independent group that advocates for evidence and that crucially builds the evidence with the patients and staff.

CM: You've been with us since the start of our journey, Mary, and we started the first series of the podcast, or, sorry, the first episode of this series of the podcast, with some reflections that you had about things that have gone badly wrong. And the way that we've structured the whole series of the podcast is to sort of work backwards and looking at all the ways we can be better as doctors at making sure patients stay safe under our care. We've covered topics such as why it's important to be a compassionate colleague. The bureaucracy around keeping patients safe in the UK. Why and how it can be hard to speak up. How to be a better listener. And blame culture.

We've covered a lot of ground when it comes to learning how as individuals, and at team levels, we can improve safety. So it can feel, I think when you think about a lot of these things, especially these patterns that recur, it can feel very depressing, especially when you think about that amnesia. You've

been doing this work for a really long time. Do you get a sense that over that period of time things have improved or are starting to improve?

MD-W: Absolutely, Clara. I think it's been an absolutely fantastic and eye-opening series and I think you've brought together a huge number of themes and offered really fantastic insights across the board. And I think you're absolutely right, this practical challenge is a really key one that we kind of need to confront. I think things are improving. Interestingly, there was a very important study published by Harlan Krumholz and colleagues in the States just last week, and that shows that there have been improvements in patient safety over time.

We've got some really good examples that are really quite compelling in the UK as well. I think the reductions in healthcare acquired infections have been impressive. That was a huge problem just ten years ago. We've had reductions in stillbirths and there are other indicators that are improving all the time.

I think where we're still struggling a bit is with these kind of organisational degradations, for want of a better word, where an entire unit or service seems to kind of go off. And as Bill Kirkup has said, the really depressing thing there is the recurring features, and that can feel quite demoralising because it feels as if we're kind of banged into patterns.

What I would say as well, is that if we look outside healthcare, so you can look at things like oil rigs, you can look at things like the building industry, you can look at things like the Space Programme in the States, you can even look at football, that there are examples of recurring disasters and things have improved over time. Now there are things that work when you're trying to improve over time and there are things that don't work, which I'd be very happy to talk further about.

CM: I guess I'm interested, when we've talked about evidence and we've talked about patterns, and then we've talked about measuring when things go wrong and how we do all that, one of the things that occurs to me is, are we measuring the right stuff? So not only measuring are we keeping patients safe, but are we looking at the right data points to actually identify outliers or those teams or areas where things seem to sort of recur? And I guess my second part of that question is, is that data always quantitative, or actually are we focusing too much on the numbers and not thinking enough about the other data, the human data?

MD-W: Very insightful as always, Clara. So we absolutely need to have that quantitative data and we need to be using it in highly intelligent ways. What can happen with monitoring data is it can become kind of bureaucratised in a funny kind of way and lose it's meaning. There is absolutely no doing without it, that is essential, but I think we have to complement it with other forms of intelligence. We sometimes call this soft intelligence and that's kind of listening stuff, it's listening to stories, it's listening to people who don't often get heard. They could be the cleaners on the wards, they could be the

healthcare assistants, they could be the patients themselves. And that kind of gathering that kind of data is just as important and also needs to be interpreted and acted on in the right kinds of ways.

The challenge for organisations is that that kind of intelligence is often very difficult to process through institutional systems. And one problem we've become very interested in is the problem of forbidden knowledge, and everybody will have experience of this. Where you know there's something really dodgy going on, or they're putting possibly a dodgy individual, and it's extremely difficult to give a voice to that because it's got some kind of a cult quality or it's dangerous to speak out about it. Or you're not completely certain. So I think there are multiple forms of points of intelligence that we need to be looking for.

I think what's also important is to distinguish cultures, if you like, between what we like to call comfort seeking, so that they're looking at data, and what they do is they tell themselves a kind of comforting story about what it says. But if you go into an organisation that's problem sensing or a service that's problem sensing, they're using that data in a completely different way. They're saying, how can we make ourselves better? What went wrong there last Tuesday? And they're much more creative and much more interrogating, if you like, and they see it as a source of improving rather than a source of challenge.

CM: I always think back to Amy Edmondson's work on psychological safety and her brilliant TED talk on that. Because I think that before I'd watched that, so much of what was tied up in my mind about reporting errors or mistakes or anything like that, was that's bad. And actually understanding that being able to report those things, evidence of psychological safety of a team, and therefore you can learn from it, that always feels…it feels like things are safer and better when that happens. Do you think that in terms of that improvement that you've seen over the years, do you think that that is something that we are getting better at, being able to hold the mirror up over time?

MD-W: I think in some places. I think it's quite variable. And I think one of the challenges that we have now of course is that the structural conditions have shifted. So much of the improvement occurred during relatively stable periods of staffing. We're now unfortunately into crisis mode, we have major issues with workforce and being able to staff units and services safely, and that does change the game. Avedis Donabedian, who's the father of one of the founding parents, if you like, of the quality improvement movement, says, outcomes are determined by two things: structure and process.

Quality improvement is traditionally focused on processes, how do we do this more efficiently, how do we do it more safely? But structure is just as determining of outcomes, and if you don't have the structures in place, everything falls apart. So I think were going to have to be really alert to the risks that are now coming into the system because of the safety issues. So I think things are getting better overall, because I think we're learning a lot

more about how to control risk, but we also need the structures to be in place to allow that to actually be delivered.

CM: And maternity and maternity services has been something that we've come back to a lot in this podcast. And I think it's because a lot of the big investigations and a lot of the big reports have been around maternity services. Something that really struck me and that Bill Kirkup said very early on, and I think you reiterated, is that more often than not, it seems that patients, patients' families, and the media, bring problems to light in a way that doctors and clinicians and nurses cannot always do. And I still don't really know why that is, why the system is set up so that that ends up being the way that things are. And I wondered if you had any thoughts or reflections on that?

MD-W: Yes, and again this is actually something that we see in other industries. So there's a whole literature on disasters and what happens in the lead-up to disasters and why they're often surfaced actually in the same way by advocates or others, rather than the industry itself where it's happened. And I actually think there's an ongoing role for patient advocates and activists. That's really very important to keep in the system. We also don't want it ever to get to the stage where we have to have those, but once they have begun to recognise a problem, I think it's enabling that voice to be heard. And I think some areas are actually underserved because particularly vulnerable groups just may not have activists working for them. So I'd like to see more attention given to those groups that may not have the same voice available to them. So I think they have a very important system role, but we also need to do more to essentially not get to that point.

So if you look at the disaster literature, there's what's usually called an incubation period, and this is where things are beginning to go wrong. And we know they're very characteristic processes, things that are happening during that incubation period. And there will be things, like we've already discussed this concept of normalised deviants, so things are beginning to slip, and because it's happening over time, you've got drift and people are tolerating it. There may be a lack of clarity about where responsibility lies for fixing it, and this is a huge problem for healthcare. And it may also be the case that you get an ingroup effect where essentially there's norming going on of each other.

And there's a beautiful description in the disaster literature: when the disaster occurs, it's an abrupt and brutal audit of everything that was going wrong before. So when the disaster happens, it's not that moment, that all kinds of conditions have led to this happening. So there is something about getting better about knowing about this, and basically recognising this is an incubation period, that this isn't normal. Again, I think doctors in training have a huge intelligence around this. I mean, you're going around from site to site, you see different things, and again, I think we could do better with listening to the kinds of intelligence and structuring that and learning from it as things are going along.

CM: I think you can be in an incredibly fortunate and unfortunate position as a trainee…

MD-W: Yes.

CM: …in that you see these variations of practice, and there's always going to be variability. And sometimes you go somewhere and you think, no, this is a real outlier, but there doesn't seem to be any part…there isn't a place to have that voice that you talk about. And then I think…what was the other thing you said, about forbidden knowledge, it's almost forbidden knowledge that everybody knows those hospitals that people don't want to go to and that there are problems. But you're not really allowed to talk about it because actually it can feel like it's an impossible thing to fix.

MD-W: Yes. So what you're describing there, Clara, is a classic institutional problem. When you say there's nowhere to go, that's exactly what it is. So this is again very well described in other industries and it's called the problem of many hands. So it's not like there's any shortage of agencies and bodies and organisations in healthcare, but what there is a challenge is locating exactly where the responsibility for action might lie.

And again not specific at all to healthcare, I think there's probably a very nice piece of research to be done, to think about how essentially the intelligence that doctors in training are harvesting could be used in a more productive way and to de-risk forbidden knowledge. Because it is very often the case that everybody knows about a problem, but actually it's not known, if that makes sense. And I'm sure Bill Kirkup says exactly the same thing. Often when you arrive on the scene, it's not like this was a kind of completely fresh problem.

CM: Yeah, I think a lot about how those places can get out of that cycle? Because it seems to me that certain hospitals and certain departments, they become trapped in this sort of really nasty vicious cycle of failure. They get a bad reputation. They end up generating more outlying clinical care, the reputation gets worse, then trainees dread going there, and so on and so forth. And patients as well are so much a part of that. Patient on the ground will say, yes, that's my closest hospital but I don't want to go there. I would rather drive two miles more down the road to get somewhere else.

MD-W: Yeah.

CM: I've thought a lot about how you fix that? And the only thing that I can keep coming back to in my head is, do you just sack everyone and start again? Or is there another way that we can take those places trapped in that cycle and actually build back better, for want of a better term, from the ground up?

MD-W: Yeah. Again what you're describing is very familiar, it's a kind of death spiral, that once an organisation has crossed a certain threshold, all of these rachet effects start to kick in. And there just has not been enough

research about what to do with organisations like this. What I can say is, and this is again something you'll find all around the world and not just the NHS, and, in fact, not just the healthcare sector, is that in every one of those apparently challenged organisations, there are going to be bright spots, and that's one of the things you can work with.

I think there's something really important about learning from what's going well and this is a kind of increasing momentum in the research community, is understanding what characterises good and then supporting units. Because I think this slapping them because they're bad just doesn't get anywhere. And it just, in fact, increases this sense of being under the cosh, and so on. I think what I would like actually is…sacking everybody clearly isn't an option because we don't have that, there are all kinds of HR reasons quite apart from everything else. And also most people are good people, and with the right support and the right kind of customised package of things and a positive sense of what they can achieve, I think we could go a very long way.

[Laughs]. So my other comment on this is that I think HR has remained the unexplored and unsupported end of the health service. It doesn't get the recognition as a kind of real challenge that needs to be tackled. I think there are all kinds of things to do with how we look after people. Basic things like do people have somewhere to lock their rucksack during the day? Do they have somewhere they can make a cup of tea? Do they have a clean toilet they can use? All that sort of stuff really matters, and it matters not just because they're things you want, but also as a sense of valuing people.

The rota thing I think drives everyone completely mad, that you can't predict whether you can get off for your wedding. There are lots of HR type things that could be fixed. And there's something about fixing those, because when you go into high performing organisations, that tends to be one of the things they've got right. And that sense of people feeling valued, that they're an asset, that they are loved in some sense. All are just so important and so easy to not recognise as being the heart of what matters.

CM: I think that's been the biggest learning point for me out of this podcast series, is I would never have thought that all of those things, like where do I park my car, can I park my car, can I leave my stuff somewhere, had anything to do with patient safety. But what almost every episode and every person I've spoken to has gone back to is, what I frame as that, almost like a Maslow's hierarchy of doctor needs in my head. When you get to work, does your badge work? Do you have somewhere to park? And actually most doctors, if you ask them, will say that the most stressful thing is not looking after the patient that's trying to bleed to death or die on you, it's actually dealing with HR stuff. Not individuals within HR but just it's a perpetual frustration.

MD-W: The system.

CM: Yeah, absolutely.

MD-W: Yeah, it's a feature, it's an infrastructure that I think has not had attention or support or investment. And it's again, I think actually where you could do an awful lot to co-design what good would look like, and then work from there. But I think there just isn't even the set of common expectations. And I do think it's performative as well. As you've just said, it's that feeling that I am valuable and I am valued that's so important to people and it just has to be got right and just isn't always. And it just matters so much for people feeling that they are being supported to do the best they can do for their patients.

CM: And I think setting that up is something that we look at as part of patient safety, is the beginning of that. If you talk about clinicians feeling like they belong and like they're valued, if that is a part of patient safety, I think immediately we start seeing it differently. We don't see it as something that is nice if you have it, but if you don't, like never mind. It is essential to the way that we work.

MD-W: I think absolutely. And I think linked to this, then, it's not quite an HR thing, it's actually something where there has been a lot of attention, but I think not always the implementation, is the communication with each other and teamwork elements to things. But you are trained now in medical school in how to communicate with the patients, and quite right. It's not just something you're born being able to do. Communicating effectively with the patients, you can be trained to do it and it does make a difference. But we don't always see the same quality of investment going into communicating with each other, or how to make teams work.

This is quite frustrating to me because this is one of the areas where we actually have an excellent evidence base and there's a really fantastic evidence base, for example, on communicating in an emergency and what you need to do. And the thing is, you can't make it up, you can't improvise it in the moment, you have to be trained, you have to do the simulations. And when it happens, then, when there's a brutal and abrupt audit, that's when it really matters. Again, I just don't think we have that consistently at the forefront of what we're doing.

CM: To what extent do you think tribalism between both specialties and also different clinical teams? So I'm thinking nurses, doctors, midwives, maybe even HR. How much of a part do you think, or do you think it has a part, to play in what goes wrong? When inevitably something goes wrong, is that as a result of that, or is that just an unfortunate coincidence?

MD-W: I don't think there's very good evidence at the moment on tribalism. My sense is that it is actually not the problem it used to be and I think the advent of multidisciplinary teams and multi professional training has made a huge difference there. And that's what you would expect because the evidence suggests that that makes a difference. So what I have seen is a lot of respect between the professions. It's not everywhere and some disciplines are better than others, shall we say. But I still think there's a job to do with

the coordination work. And again, it consistently feels to me like we don't value coordination if you're not right in there, in the clinical field doing stuff to patients, what you do doesn't matter.

And actually what we see in maternity is, for example, the unit coordinator is an absolutely key individual, just like the air traffic controller. Nobody would think about landing a whole load of jets without the air traffic controller. And that coordination function I think is just as important in healthcare and helps to reduce a lot of tribalism and so on. When you do find tribalism, it's really very unfortunate and you have to do an awful lot of remediation work to sort it out. And my sense is, we've been talking about maternity, we've been doing a lot of work with the two Royal Colleges, the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives. And certainly at institutional level, that's working really well. They completely respect each other.

I suspect you will find pockets of where doctors and midwives don't get on. And again, going back to our comments about forbidden knowledge and soft intelligence, there are things you can do to intervene and I'd be very keen to see that kind of intervention happen.

CM: I think, just picking up on one of the other threads that's gone through this podcast series, which again I didn't really expect to end up talking about, but is our own ability to admit that we're wrong about things. I guess I thought a lot about whether this is just a doctor thing or whether this is just a human thing, but I wonder if a lot of that, going back to your original point about the learning and how we generate learning, is about saying, okay, that didn't work, let's try and do it better next time. Instead of saying, that didn't work but I can't possibly be wrong, so I'll just do it again, but maybe more aggressively next time and then it will work.

Do you think that that's a generational thing? Do you think that as a generation of doctors, we're now much better at being able to say, oh, we're wrong, or we can question ourselves? We're going to take a bit of time off work because we're struggling with our mental health. Whereas my parents' generation definitely probably, as doctors, definitely probably, definitely, wouldn't have done that. Do you think that's something that we're getting better at? Or again, is it something that you haven't really seen a big change in?

MD-W: I think some changes. So I think the challenge with admitting you've been wrong is a human thing, not a doctor thing. And Amy Edmondson's book is about her fantastic analyses. Some of it is drawn from healthcare examples but a lot of it isn't, so it's generic. And nobody wants to be wrong. Again, it's actually something we can be trained in how to do it, and simulations are very key here. Victoria Brazil in Australia has been doing absolutely fantastic work on this and the importance of the debriefing afterwards. So it's safe to say, oh my god, we messed that up. Or, we really should not have handled that in this way. I just think simulations have a huge role, and it's again what they do so much of in other industries. Even if you look at

the Army, nearly all of the training is effectively simulations. So I think a really key role there.

And some of psychological safety is being able to hear when somebody is pointing out you're wrong. I think training people to say, oh thank you, when somebody… That doesn't come naturally, it doesn't come naturally to any of us [laughingly]. It's somebody letting you know you've slipped up or you've forgotten an instrument or you haven't done that closure correctly, that's a gift to you, but we don't train people, I think, in how to do it.

On your point about the generation effect, it probably is different. I'm very pleased to see people now being much more comfortable with admitting they're feeling vulnerable. Much more willing to come forward, and much more willing to accept help when it's offered. Again that probably isn't universal but it's certainly something that I've noticed in the generation I'm in versus yours. So I'm very happy to see that.

I guess one of the issues then is where essentially the care for the carers is coming from. People are asking for help, I'm not sure it's always fully available, particularly with the conditions in healthcare at the moment. Supporting a lot of people is also psychologically demanding for the people doing the support. And my sense is, from having worked with doctors and medical students over the years, you're really great at looking out for each other a lot of the time, but sometimes that can be quite demanding for the person doing the support. So I'd like to see a little bit more on that as well.

CM: In terms of things that we can do going forward, both as individuals and on a systems level, what do you see being the biggest challenges that we can find solutions for in the next five or ten years? To improve not only how we experience healthcare as people giving it, but also how our patients are experiencing that healthcare?

MD-W: A fantastic question. Okay, I think there are actually several really practical things we can do. One of them I think is going back to our conversation from earlier. I think finding the examples of places that are doing things really well. I think doctors in training can help us do that. So you don't have to come on board all the time with concerns, but you can tell us, this was brilliant here, this is how they're doing this. So I think coming forward with those positive stories is really helpful.

I think the second thing, and THIS Institute is working on the infrastructure to this, so I'll come back and share it with you. We're helping to cocreate the solutions and forming communities of people who know what good looks like, and then they will help figure out how do we get there, and help testing the solutions. Which can be very small contributions from people that can be aggregated. And when you feel you're part of the solution, I think that's very important.

I think picking up some of these neglected areas of activity, like HR and so on, and trying to find examples of, oh, they have sorted out the rota system

there, what can we learn from that? So I think bringing that mentality and learning forward. I think the big things like the absence of infrastructure for some of this learning, the recurrence of problems has to be sorted out at structural level. So I think helping to identify where we have too many hands and not enough action is another things doctors in training can do. But I think what you can do also is bring this unifying vision of what we could achieve and a sense of how we can achieve it within the available resources.

So we've learned an awful lot actually over the last 20 to 25 years of the patient safety movement, the quality improvement movement and it feels like a moment now to capitalise on that and re-bring it to life. And I think doctors in training are an absolutely key part of it. They're a huge assets for learning and for making things better.

CM: Well, obviously as a doctor in training, that's music to my ears [laughs]. I think you're so right, there is so much to be harvested from good practice in one place that could be translated across to other places. So that is a wonderful thing to hear.

Thank you so much for joining me again today, Mary, and for your fabulous insights. I feel like every I speak to you, I come away with so much to think about in the days following.

MD-W: Thank you very much, Clara. A fantastic interviewer and I really enjoyed talking to you, and the whole series has just been fabulous. Thank you.

CM: Many thanks to Mary for joining us again. We've added some of the links to the things that Mary's talked about there in the podcast notes.

We'll be hearing from Bill soon, but first a message from our sponsors.

S: [Advertisement]

CM: Now time to hear from Bill Kirkup. When we started this podcast, we wanted to hear from him specifically because of the work he does carrying out investigations into when care has gone drastically wrong. Unfortunately, Bill's actually now leading on another investigation into maternity services. While his report is due soon, we didn't want to pre-empt any other recommendations before they're first given to the families involved. So today, we're going to focus on how this work has affected him as a person and his tips on carrying on despite the emotional toll of patient safety work.

Good morning, Bill, welcome back. Thank you so much for joining us this morning. So for those listeners who haven't heard you speak to us before, do you want to start just by introducing yourself?

BK: Yeah, thank you, good morning. I'm Bill Kirkup. I had a career as a clinician and as a public health doctor, and as a manager of sorts, and retired at the end of 2009. And then found myself being asked to do investigations and

I've sort of made a third career for the last 12 years or so out of doing investigations, and find it challenging but very rewarding.

CM: In those situations, and obviously you see a lot of very bad situations when you go and do investigations, is there any way that you can guard against that burnout or that moral injury from seeing harm or potential harm happening to patients?

BK: Yeah, I mean, I think having a network of supportive colleagues is enormously important to these kind of situations. You won't be the only one who's aware of this, the only one who this is happening to. I think being able to call on that network is really important, as well as the formal mechanisms of support, like the BMA. One thing that distresses me a bit in comparing current practice with previous practice is that we've sort of kicked some of the props out from under that.

When I was a trainee, okay, it was shortly after Noah's flood I know, but we had a system called AffirmAssist. And yeah, I know that the hours that we worked were stupid and unsupportable and had to go, but it does seem to me that we lack now in many respects the supportive environment that that gave you. That you knew who you working with, they knew you, they got to trust you. You knew that there were people there who were going through the same things as you that you could talk to, and would talk to every day. I regret the loss of that and I think it would be interesting to see if there was some way in which we could re-establish some of that.

CM: One of the other things that you mentioned in our first conversation that I've reflected on and I think it's become a bit of a common thread through this series, is about reflection, both the ability of an individual to reflect and on an organisation to reflect. And the difficulty we have in admitting fallibility in ourselves or within our organisations. Do you think that going forward there's any way of building that reflection and that admission and sort of fallibility, or the fact we don't always do things right? Do you think there's a way of building that in?

BK: I think it is changing, but I think it's changing far too slowly to be comfortable. And I think there are still too many echoes around of the previous system where what you saw amongst the people who you aspired to be one day was the reverse of that. They were not reflective, they were finding great difficulty in admitting that anything might have been done better or anything had gone wrong. And suppressing any discussion about it, and, most importantly, suppressing any learning about it. And I think there are two things.

One is you don't learn so you keep on making the same mistakes over and over, and that's a really common feature of everywhere that I've investigated, in every setting. But secondly, it leaves people feeling pretty unsupported when it happens to them because they daren't admit that anything has gone wrong. And it's a pervasive culture. I believe it's improving and I believe that as we improve training and as people come

through, with hopefully better ideals that they want to live up to, it's going, but I wish it was gone a long time ago. It shouldn't still be around.

CM: And when you see these…you know, you've mentioned networks, when you see things not being done right repeatedly, as yourself, how do you guard against becoming incredibly depressed, especially when it feels like the pace of change is so slow?

BK: [Laughs]. Yes, there is that temptation. And the other thing is listening to the accounts over and over of people who have been harmed by these things, it's difficult. I mean, I don't want to make too much of that because it's nothing compared with what they've been through, but in the end it does get to you. And I think it's the same thing, I think it is really important to have a network of people who are going through the same thing with you and to be able to share these things with you.

CM: Thank you again to Bill and to all of our guests on the podcast.

We're delighted to say we'll be back with another series of Doctor Informed soon. But we will be changing things up a bit. Instead of a deep-dive into a single topic, such as we've done with patient safety, we recognise that there's so much going on in healthcare at the moment that we're going to be covering a much wider topic base and bringing in more voices from people at the frontline of the service to hear what's happening to all of you.

We're really keen to hear from our listeners for ideas for future discussions, reflections on the topics we've discussed today or in the past, so please get in touch. If you like our show, I'd love it if you could support us by leaving a review wherever you get your podcast or share with the people that you know. Tell your friends about it, that really helps people find it. If you'd like to hear other episodes, subscribe to Doctor Informed on Spotify, Apple Podcasts, or wherever you get your podcasts from, and you'll be notified when our next episode, in this case our next series, is ready. Until then, goodbye from us.

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