Episode four - Vulnerability in leadership and MDT participation

Debbie Draybi: I'm Debbie Draybi from the Clinical Excellence Commission and am pleased you can join us for this four-part podcast series with Dr Clare Skinner & Dr Dane Chalkley. This podcast is part four of a four-part series on M&M leadership and case selection Right Material and Right people.

In this segment we explore Vulnerability in Leadership and multidisciplinary participation. Clare and Dane discuss the importance of normalising human error and being able to reframe errors as a learning opportunity rather than alienating clinicians who made the error.

Clare emphasis how errors are really a growth moment and being able to support clinicians to grow and learn from those experiences and to share their level of insight that they have when that happens. They also talk about M&M leadership and the importance of modelling vulnerability and being able to demonstrate their own learning experiences from errors.

We also go into a discussion about Civility and Tribalism and the importance thinking about that when we are looking at multidisciplinary engagement and discussions. I hope you enjoy this segment and thanks for joining us.

Dr Clare Skinner: I really try, from the point of view as the head of department and the Chair of an M&M meeting, to remember what it was like to be a first term intern in the Emergency Department and I'm actually surprised that people forget that. So, I think that's what you have to do. You have to remember what it was like to be the first term intern and just how overwhelming it was.

Debbie: Yes, being able to position yourself there.

Clare: It's all about empathy, compassion, and connection.

Debbie: Where they're at in their development.

Clare: And it's about humanity. We're human beings, we do things for a reason.

Dr Dane Chalkley: The paper that was written in the UK in the GMC 'to err is human' I think missed the point because the actual expression is 'to err is human, to forgive is godly'. I think that's wrong and think it should be 'to err is human, to forgive is human too' and, ultimately, we need to be focusing on how we look after each other and learn from our humanity.

Clare: And that's a really important thing you just raised as well. The clinician who's been deeply involved in an incident - whether it's a mistake or complaint or anything that's gone wrong - they've had the deepest learning of anyone in the team, and they actually are your best ambassador for quality. And I see this happen time and time again in health systems where something goes wrong, that clinicians held out to dry/ removed from the system when they are in fact the person that had the best learning and their experience is shared in a compassionate way that they want with other people is your best learning, but we write that off.

It's a massive problem with our system that we don't engage those people because I know the mistakes I've made, clinically, have absolutely shaped me as a clinical leader. And if I didn't have that there's a richness there that we ignore at our own peril.

Dane: I think you're absolutely right, and I think there's a resource there for learning about the particulars of that case and the nuances of that, but also meta quality, learning about the processes, learning about how someone goes through that process. Learning what an RCA is like to be in and sharing that and sharing how that feels so that other people are either prepared or who have also been through that. Yeah, I felt that too, and this is how we should look after each other. And this is how we should look after and support each other.

Clare: It's such a growth moment and I think we're scared of it, so we push it away, but it's a growth moment and it's where we need to support someone, encourage them and bring them into the team more than ever.

Debbie: The level of insight that they've gained from that experience is so profound, isn't it? And we're not engaging that.

Clare: And you can make a positive.

Dane: I've had some of my junior staff, some of my registrars, and seen some of my colleagues go through RCA processes and you can see for weeks and weeks that they're still in the background the cog ticking. You've spoken to them initially and made sure that they're okay and you counsel them and debrief them and then you keep in touch and you can see how things change, you can see how things develop, you can see how they process it. And that's a really rich source of a) humanity and b) a learning opportunity.

Clare: I think we oscillate in our clinical confidence. You know I'll go through phases where everything goes right and I'll get confident, and then something goes wrong and I dip again, and I oscillate. And I always hope that the thing that goes wrong is a tiny thing that doesn't impact on anybody other than me, and that will be enough to put me back into caution mode. And I think we all oscillate, and I don't think we acknowledge that publicly enough.

Dane: Yes, you can be hanging on an absolute high where you feel like a clinical legend and then just one tiny conversation with someone can make you just drop to the bottom and then feel deeply, resolute, when we need to go and see a patient and talk to them.

Clare: Or pick up the phone. I think we need to get better at this in healthcare, don't we? Where we are much more empathetic to people.

Debbie: And being able to share that? That's an experience that everybody has where something goes wrong and it has a really negative impact on the patient, but also on them and their understanding of their capacity.

Clare: But also, it's a big learning when you know we're all on the phone or talking to colleagues all the time and when they miss some things to actually check them in a really positive way. So 'have you thought of...?' instead of "no no you didn't get this". Yeah, we are moving beyond the M&M a bit, but this is really important to remember: when someone misses something, they didn't do it deliberately. They were distracted by something, or there was a transfer with other patients or a whole bunch of reasons. So, we need to be really mindful that in all of our communication, not just the M&M.

Dane: We have a new forum which is for the consultants and the heads of departments and it's a Zoom forum in the evening run by very senior DMS's and executive DMS's. One of the ones we had was about shared experiences - and that was for all doctors - and it was a group of consultants just sharing their experiences of error of complaints through the HCCC of their own ill health of having junior members of staff become very unwell or taking their own lives and that sort of thing demonstrating their vulnerability and how these things have affected them is incredibly powerful and I think that is a part of something that you can bring to an M&M meeting/quality meeting.

As we said earlier, just demonstrating that we all make mistakes. We all make mistakes and it's about how you learn from them, not about beating yourself up about it.

Debbie: I think that's a really critical point around the power of that shared experience. Because you're normalising it and you're giving people permission to be vulnerable and to know that this is part of the experience in your profession.

Dane: There's no doubt the consultants and senior clinicians and senior members of nursing staff are put up on pedestals. We are perceived as being invulnerable, as being infallible, and it's just so not true. Hiding that away and not sharing it with people means you're missing out on lots of important stuff.

Clare: Actually, I think some of the incivility and bad behaviour we see is projecting that anxiety.

Dane: 100% agree.

Clare: You've got more safety nets the more junior you are and the more senior you get, you don't have the safety nets anymore.

Debbie: Yeah, there's more at stake isn't there? Yeah, greater risks to being vulnerable.

Dane: Yes, that's right. And you know I think when you're on that pedestal and you know you're on that pedestal, then you've got quite a long way to fall, and it can be a bit windy and worrying out there. I personally don't really care anymore and I'm quite happy to demonstrate my vulnerability. And that's not because I'm incredibly confident in what I do, it's just because I think I've moved away from thinking that I am invulnerable and realising that I've made enough mistakes now to know that.

So, what I have is that I've got a failure friend which is someone whose opinion I respect but also know is very kind so when I do make a mistake, I go to them and I know that, if he gets peppermints, he's going to say kind things!

Clare: I try to be that failure friend. I say to my team that if something bad happens and you find yourself awake in the middle of the night, I'd far rather that you ring me up and we talk it out than you do it by yourself. I think the best clinical leaders keep their feet firmly on the ground and it's how you do it and you've got to do it in a way that people have confidence in you. But also, it's clear that you're human and you're authentic and you're vulnerable too. 100%.

Debbie: It sounds like a really critical part of that is kindness.

Dane: It is. It's so underrated and it's so important. And yes. If you if you took a poll of year one medical students, year one nursing students, and year one pharmacy physicians, you'd say why are you doing this, and they'd say because I want to help people. But then somewhere along the way, we lose that sense and the kindness.

Clare: The system is so tough on people. I see this as a manifestation of being in a toxic system. I'm a big believer that civility saves lives and being kind. But I also recognise that when people can't do that, it's because they can't, not because they want to be mean/nasty. It's because they have grown up in a toxic system and their resources are exhausted.

Debbie: Yes, absolutely. Then, because of their experiences, they've really got into that survival mode where it's no longer safe to be kind.

Clare: Try something else which has come up here, which is the notion of civility and tribalism. It's very easy in your own team meeting to dump on another team who's not present and you need to actually take great care as facilitator to make sure that doesn't happen as well. Because we operate in a system, I think it's really important that an M&M meeting is multidisciplinary, so I don't think it should be just doctors. I work in a multidisciplinary environment and I love the fact that I work in a multidisciplinary environment. I want the voices of the other professionals in my environment in the M&M because they'll often see things differently, which is really valuable. And I think the best, highest functioning teams get to the point where they see things together.

I think civility is really important here. You've got to be really careful around your language, and the M&M can have a little bit of levity in it, and can have a few jokes in it, but it can't be at anyone's expense and particularly can't be at the patient's expense. And I just I think in any investigation you do need to always be aware that this is someone else. The patient is a real person. They have a family, they have a life and you need to be respectful of that. So, I'd like to give a real plug for this. This is a respectful place, and the language must be polite.

Yes, you can be a little bit light, but you can't do it at anyone else's expense, and you need to be aware as well of the system you work in. So, it's not okay to say "the orthopaedic registrar blah blah blah blah..." because the orthopaedic registrar is also in a system that's not working well, so you need to see all of it from a system perspective.

Debbie: Yes, that's really a critical point in terms of ensuring there's respect for people, not just the patient, but other clinicians involved as well.

Clare: People often will see minutes from M&M meetings, go through the quality committees, and they're seen by other teams, and quite often - and maybe I'm over sensitive to it - I see "ED did this, ED did that..." in other teams' M&M notes and I think basically we should see ourselves as part of a continuous system. And if you see something that you didn't think went right in someone else's team, then you have a responsibility to talk about it and nut it out, not just shuffle it away.

Debbie: In situations like that have you had experience of inviting other teams in and has that been useful?

Clare: Yes, it has. Dane talked about paediatric M&Ms. Paediatrics would be the most common team that we invite in as well.

Dane: You have to be careful. Ultimately, if it's a case where you want to discuss, you know the events of Human Factors, then it's important that you choose a case where you know the clinician that was involved on the other team is someone who would agree with those core principles. There's no point in just inviting the whole neuro surgical team. For example, I would invite the neurosurgical registrar who was there if I felt that they could contribute to a safe and well-intentioned discussion. If it was just a matter of putting a tick in a box, I wouldn't do it.

Debbie: So that understanding of Human Factors is really critical.

Dane: Yes, I think an understanding of what you're trying to achieve from a quality meeting or an M&M, those partisan attitudes and all that tribalism, is really, really important to overcome, and I think that can be really useful - inviting people from other teams. Having “yes, oh look, there's Tom from, you know, from orthopaedics. Thanks Tom, what did you think? I think it went really well but I want to see some challenges” and then that person becomes a person who's learning with us towards better patient outcomes.

So, everyone sees that person and that team in the right light, and they can contribute towards our learning as well. And I think that's a really important two way. That's a symbiotic relationship which is really important because, as Clare said, we're all working in one big system.

Debbie: Absolutely.

Clare: And tribalism is a form of cognitive bias. So, I think one of the most successful joint M&Ms we've had in our emergency department was actually with the Mental Health team. ED and Mental Health traditionally have difficult relationships. Our shared patient group are highly vulnerable and complicated, and doing that together was wonderful because suddenly everyone sees the other side of the system. Well, the reason that person was in ED for that long was because of this, this and this, and the reason we referred to you then was because we were worried about this and this. It's been fantastic for the teamwork and the empathy between the two teams.

Debbie: It's really building those relationships, isn't it?

Clare: But you don't want to do it every time.

Dane: Yes, I can't see the point in having an M&M where you go through the Krebs Cycle or talk about the complexities of achieving a great one view with a video living scope McGrath versus CMAC or whether not this particular herniorrhaphy or osteotomy is the right thing to do in this particular situation when you look at the angle of the button... there's no point in that because you have lost your audience because your audience is going to be multidisciplinary and it's supposed to be an interprofessional learning experience. So, you have to pitch it right as well and, again, that is the role of the facilitator.

Clare: What I do there is you don't go through the detail, but I provide a whole bunch of links, so I'll send out the slides afterwards with links. So, you can look up this here or here's a great article about this.

Debbie: And that's the challenge. You've both mentioned that the content needs to be pitched at a level where you're engaging the multidisciplinary participation and you don't want to get too technical or specific that it's not relevant to the other disciplines or they can't really engage with that material. It's not their areas of expertise and then it's around how to best present that in a meaningful way with the principles and the themes. I think it's a skill to do that, isn't it?

Dane: It is and if you're going to present a big case or a couple of big cases then sharing the presenting between the specialties is really important. Having a nurse presenter, a physio presenter or a pharmacy presenter, or someone from the sexual assault team or whoever, as long as you do prepare quite well in advance with that presenter to make sure that they understand what the principles of what you're hoping to achieve are.

Clare: I'm quite picky about who is invited to the meetings and I think you need to make sure it's the core team and they know and trust each other. And occasionally I've invited members from other teams into our M&M meeting, but I've done it with a lot of preparation and making sure people are comfortable with that. I think you know we have stuff that's routine in the M&M that comes up all the time, and that's fairly safe, but occasionally, particularly in ED, M&Ms will have a big sentinel case - a really, big, hard thing.

The ones that come to mind the most are the death or a significant misadventure of a child, particularly. And those are really difficult, and you have to make sure you give them space and it's really tempting to invite other people in to discuss some of these cases, but I think actually it's about the core group. So if you want it to be safe, you need to really think about who else is in the room and make sure that if you do invite other people in - like we will invite Paediatrics in occasionally, and I've invited the Mental Health team occasionally into our ED M&M for big cases - you need to make sure you talk to them offline and make sure they know what their role is and what the culture of the meeting is in advance.

Dane: So, what we've done is we've established that every third M&M is actually a paediatric joint M&M which has allowed ourselves and our paediatric colleagues to actually develop that style within that.

Debbie: Thank you for listening to this podcast with M&M leadership and case selection Right Material and Right people: I really hope you enjoyed it. Please note this is one of a four-part series and I hope you listen to the other three segments as I continue this conversation with Dane and Clare explore around choosing the right cases.

Dane and Clare talk about the importance of leadership in M&Ms they also talk about their experiences of safety sciences and the importance of Human Factors. We explore multidisciplinary participation and it's a real opportunity to listen in and really hear the level of vulnerability and experiences that Dane and Clare talk about as they explore their M&M leadership.

Listen in as Clare and Dane discuss their insights and lessons learnt that they have had along the way in supporting M&Ms.

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