

CELEBRATING FAILURE

A way to preserve professional integrity, personal well being and save the NHS?

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SOCIETY IS OBSESSED WITH SUCCESS



"I want my kids to have a good work ethic. I believe you can achieve anything if you work hard enough to get it." -Victoria Beckham

PRESSURE TO SUCCEED



Six Principles That Guide Student Achievement in High-Performing Schools

> Alan M. Blankstein Foreword by Michael Fullan

• Children should not be allowed to:

- attend a sleepover
- have a playdate
- be in a school play
- complain about not being in a school play
- watch TV or play computer games
- choose their own extracurricular activities
- get any grade less than an A
- not be the No. 1 student in every subject except gym and drama
- play any instrument other than the piano or violin
- not play the piano or violin.

Chinese parents understand that nothing is fun until you're good at it. To get good at anything you have to work, and children on their own never want to work, which is why it is crucial to override their preferences.





DOWNSIDE.....



PEOPLE IMPROVE THROUGH FAILURE....



FAILURE IS GOOD IN EDUCATION TOO...

FAILURE IS THE Opportunity To begin again More intelligently.

~ Henry Ford

CELEBRATING FAILURE

" I Failed in some subjects in exams But my friend Passed in all. Now he is an engineer in Microsoft and i am the owner of Microsoft."

- Bill Gates -



can be the greatest thing in our lives

CELEBRATING FAILURE

THE POWER OF TAKING RISKS, MAKING MISTAKES, And thinking big



RALPH HEATH

THE PRESSURE TO SUCCEED IS PERNICIOUS





And has a detrimental effect on learners and organisations

The moral mandate to achieve success exerts pressure to succeed by fair means, if possible, and by foul means, if necessary.

PRESSURE TO SUCCEED

shonesty Cheating

• McCabe 2005 - 80,000 students from 83 campuses 25-50% admit some form of cheating

CHEATING IN MEDICAL SCHOOLS

- Sierles et al 1980 58% medical students report cheating at least once
- Baldwin et al 1996 5% cheating in medical school (80% before entry)
- Rennie and Crosbie 2001 -Dundee study 2% admitted to copying, 58% admitted to plagarism
- Dyrbye et al 2010 1.5% students admit cheating in exams but 43% falsify clinical findings



THE PRESSURE TO PERFORM

- The pressure to get into medical school courses
- Ranking in UK medical schools now a way of life
- National ranking for postgraduate F1 posts



STUDENT BURNOUT

- Medicine is an intrinsically demanding profession,
- Common amongst medical students
- Some studies estimate 50% medical students may be affected by burnout



(IsHak et al 2013)

POSTGRADUATE TRAINING

• WBAs

- Choosing straightforward cases
- Choosing doves over hawks
- Retrospective case selection



PRESSURE TO SUCCEED IN RESEARCH



Source: Journal of Medical Ethics





NATURE | NEWS

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Publishers withdraw more than 120 gibberish papers

Conference proceedings removed from subscription databases after scientist reveals that they were computer-generated.

Richard Van Noorden

24 February 2014 | Updated: 25 February 2014



New Russian doping report confirms evidence of statesponsored cheating

IOC meeting Tuesday to discuss sanctions; WADA recommends full Rio ban

The Associated Press Posted: Jul 18, 2016 8:06 AM ET | Last Updated: Jul 18, 2016 9:46 PM ET



PRESSURE FOR ORGANISATIONS TO SUCCEED

• 'You will learn that most organisations do not value failure, they do not see it as a learning opportunity but as a negative'

Tyrone Pitsis 2016



THE ENVIRONMENT OF THE NHS

- Whistleblowing
- Admitting mistakes = attracting blame



Francis Report – Freedom to speak up

• *"There is a culture"* within many parts of the NHS which deters staff from raising serious and sensitive concerns and which not infrequently has negative consequences for those brave enough to raise them" http://webarchive.nationalarchiv es.gov.uk/20150218150343/https:/ freedomtospeakup.org.uk/



ERRORS HAPPEN.....

- Error is often associated with notions of poor ability and blame
- Powerful incentives to cover up errors
- Covering up errors = obstructed learning
- Less cover up = a culture of a climate of learning from error = and less further error



ERRORS ARE NOT THE SAME AS MISCONDUCT

• Why a culture of fear and blame won't fix the NHS



• Moving away from a climate of fear about admitting error and blame



WHY DO WE BLAME PEOPLE?

Attribution theory:

- Blame helps us cope with uncertainty
- Attributing failure to an external cause may be a natural selfprotective mechanism



BLAME CULTURE

- Healthcare workers at particular risk of stigmatisation following an adverse event
- Generates considerable motivation to avoid blame
- Powerful barrier to reporting and effective learning from adverse events



CULTURE OF BLAME

- "The single greatest impediment to error prevention is that we punish people for making mistakes"
 - Dr Lucian Leape, Harvard School of Public Health



BLAME: THE DEFAULT RESPONSE

• The NHS blame culture fuels negative media reports and demotivates staff and leads to burnout

Critical Care Emergency Medicine Family Medicine 53% 52% 50% Internal Medicine 50% General Surgery 50% HIV/Infectious Diseases 50% Radiology 49% Ob/Gyn & Women's Health 49% Neurology 49% Urology 48% Pulmonary Medicine 47% Cardiology 46% Diabetes & Endocrinology 45% Orthopedics 45% Nephrology 45% Plastic Surgery 45% Pediatrics 44% Oncology 44% Anesthesiology 44% Rheumatology 43% Allergy & Clinical Immunology Ophthalmology 43% 41% Gastroenterology 41% Pathology Psychiatry & Mental Health 39% 38% Dermatology 37% 0% 20% 40% 60%

What Percentage of Physicians Are "Burned Out"?

FROM A BLAME CULTURE TO A LEARNING CULTURE



• Three steps

- Intelligent transparency
- Developing a learning culture
- Appropriate accountability

LEAGUE TABLES OF MISTAKES



NHS

LEARNING FROM MISTAKES LEAGUE

The rankings are as follows:

- outstanding levels of openness and transparency
- good levels of openness and transparency 2
- significant concerns about openness 3 and transparency
- poor reporting culture





culture

SAFE SPACE CONSULTATION

• Creating a safe space is a difficult balance to achieve

Reassuring staff that the information they give will not be passed on Department dreadth Providing a 'safe space' in healthcare safety investigations Consultation

Reassuring patients and families that they have the full facts



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Blundering doctors get protection from blame



DR BAWA GARBA AND REFLECTION

TIMELINE OF THE BAWA-GARBA CASE

FEBRUARY 2011

6 year old Jack Adcock dies from sepsis at Leicester Royal Infirmary

NOVEMBER 2015 Bawa-Garba is found DECEMBER

guilty and given a Bawa-Garba two year suspended sentence. and two nurses. Taylor is cleared

Theresa Taylor, are charged with gross negligence manslaughter

2014

including

AUGUST 2016 The nurse also convicted in the case, Isabel Amaro, is struck off

DECEMBER

Bawa-Garba is denied permission to appeal against her manslaughter conviction

JUNE 2017 Medical practitioners tribunal suspends Bawa-

Garba for 12 months, saying that "erasure would be disproportionate"





JANUARY 2018

High Court rules that Bawa-Garba must be struck off the UK medical register to maintain public confidence in the profession

MARCH 2018

Bawa-Garba granted leave to challenge her erasure from the medical register in the Court of Appeal



WILLIAMS REPORT

Reflective material

• Professional regulators that have power to require information... for the purposes of fitness to practise procedures should not have access to personal reflections

Gross negligence manslaughter in healthcare

June 2018

"Success is going from What failure to failure without a loss of enthusiasm." Success Svinston Churchill

CELEBRATING FAILURE

• A way to preserve professional integrity, personal well being and save the NHS?





Could the NHS or any modern health service ever be an organisation to celebrate failure?



Thank you for your attention