“She’s Not Dead Yet, Jim”:

Vulnerability and Retrospectives in Emergency Medicine

Al’ai Alvarez, MD
Asst. Prof., **Stanford Emergency Medicine**

Kurt Andersen
SRE Architect, **Blameless**

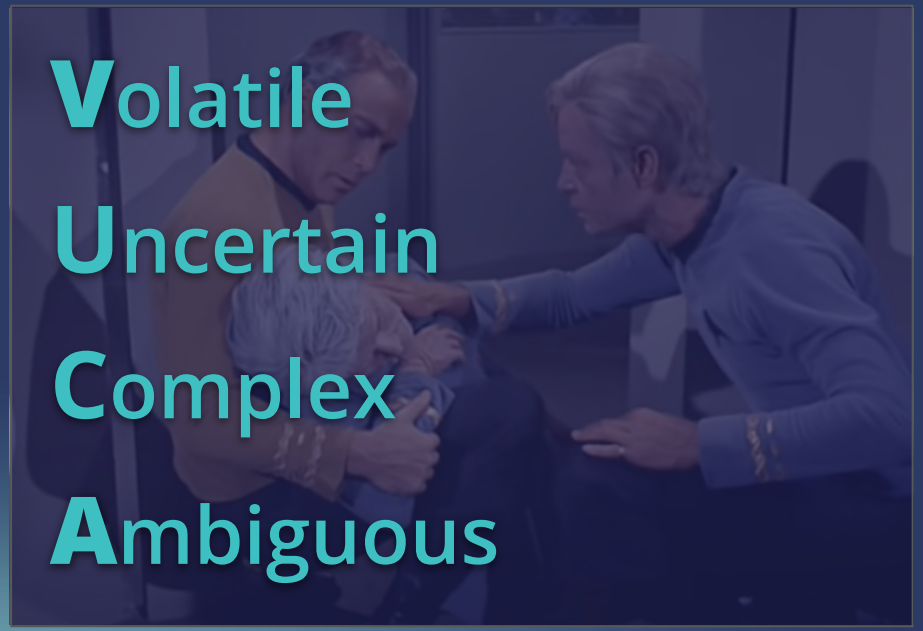
Christina Tan
Strategy, **Blameless**

BLAMELESS

Stanford MEDICINE | Emergency Medicine

“She’s Not Dead Yet, Jim”:

Vulnerability and Retrospectives in Emergency Medicine



Al’ai Alvarez, MD
Asst. Prof., **Stanford Emergency Medicine**

Kurt Andersen
SRE Architect, **Blameless**

Christina Tan
Strategy, **Blameless**

BLAMELESS

Stanford MEDICINE | Emergency Medicine

Speakers

Al'ai Alvarez, MD

Director of Well-Being

@alvarezzzy

Stanford MEDICINE

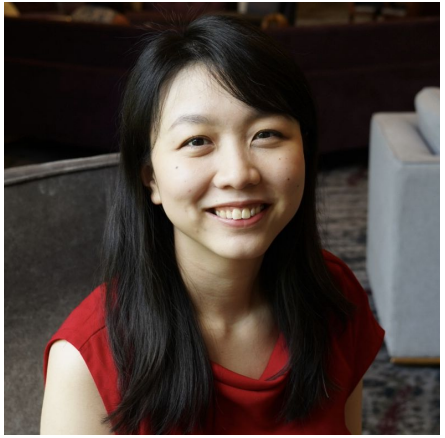
Emergency Medicine

Kurt Andersen

SRE Architect

@drkurta

BLAMELESS



Christina Tan

Strategy

@etoilezhhjd

BLAMELESS

Retrospectives in Emergency Medicine:

Immediate Debriefs & Biweekly Case Reviews

How to reduce the emotional trauma of post-incident reviews?

Preface the Debriefs

Shared goal. No finger pointing.

Lead with Vulnerability

Start with a mistake that you've made

Inspiring Ownership

"If you can change **1%** to better the outcome, what would that be?"

Level up Your Team

Getting a team member to lead the discussion

How to Make Post Incident Debriefs Effective?

Debrief Immediately

To create a shared mental model

Multiple Touchpoints

Giving people time to collect their thoughts and not feel defensive

Forward Facing Accountability

When leaders lead with mistakes they've made, they inspire the team to open up

How to coach the team to deal with self blame?

Sit with that Discomfort

"This is what it feels like to feel like you didn't do a good job"

Shared Common Humanity

"You will make many mistakes, just like me."

Putting Mistakes in Perspective

Keeping the time horizon, positive aspects, and individual limits in balance

Elevate the team from feeling like victims to taking ownership of making improvements.

Are mistakes a reflection of lack of competence or skill?

Mistakes are more common than you think

Competent people make mistakes when confronted with interruptions and context switches

Leadership can adapt accordingly

The Checklist Manifesto: Even for well trained, extremely expert people, having procedural standards that people can follow can reduce mistakes

Designing a Learning Organization

How to adapt your language to build a learning organization?

- Peer Review → Case Review
- Compassion → Resilience? Blameless? Learning organization?
- “Why did this happen?” → “Help me understand what happened”
- “I should’ve” → “I saw, I did”
- Postmortem → Retrospective

What rituals and programs can encourage learning and adaptability?

- Morbidity & Mortality, Saves of the Month, and Amazing & Awesome
- Case Reviews: track data for patterns and develop action items
- Interviewing individuals before hand
- Separate action items from the group meeting itself

Role Creation & Metrics

- Chief Wellness Officer; Director of Wellbeing
- Retention
- Dollar lost from burnt out physician

Summary

Post Incident Reviews in the ER

- Making reviews effective and reducing emotional toil
- Dealing with self blame
- Interpreting mistakes: perspective & competence

Designing a Learning Organization

- Language
- Rituals & programs
- Role Creation & metrics

BLAMELESS

Stanford MEDICINE | Emergency Medicine

Our Ask

Crowdsourcing Better Retrospective Practices @blamelesshq

- What specific practices have you found helpful with socializing learnings from a retrospective amongst a wider audience beyond those immediately involved?

Healthcare Workers' Well-being

- Support initiatives that protect mental health of physicians
- E.g. Dr. Lorna Breen Health Care Provider Protection Act
- Vaccination helps protect doctors and other healthcare workers

BLAMELESS

Stanford MEDICINE | Emergency Medicine

Concluding Reflection

Resources

- *Chatter* - Ethan Kross
- *Awaken Compassion in the Workplace* - Monica Worline, Jane Dutton
- *The Checklist Manifesto* - Atul Gawande
- *Retrospectives for Humans* - Courtney Eckhardt
- *The Centre for Compassion and Altruism Research and Education (CCARE, Stanford)*
- *Dare to Lead* - Bréne Brown
- *Incident Metrics for SRE* - Štěpán Davidovič
- *Behind Human Error* - Woods, Dekker, Cook, et al.
- *Just Culture: Who are We Really Afraid of?* - Steven Shorrock
- *Just Culture* - Sidney Dekker
- Tribute to Dr. McCoy - https://youtu.be/IAsaHZ-m3k0

BLAMELESS

Stanford MEDICINE | Emergency Medicine