Civility in the Workplace and its Impact on Patient Care

PART ONE: Why Civility Matters in a Complex World

Full Transcript – December 2024

[0:15 - 0:47] It is so lovely to be here, so my name is Chris Turner, I'm an emergency medicine physician in Coventry, which is kind of in the belly button of England, and I'm clearly not in English. I'm Scottish, I transplanted to England through love, it's the only reason why I would have gone to England and no regrets, no regrets, I live in Birmingham, which is an incredible bustling city with diversity like I had never seen before, and it took a wee while to get used to Birmingham, but I totally love it now.

[0:47 - 1:06] And I didn't think that I would be the sort of person who was standing in front of you guys at this stage in my career…for a bunch of reasons, firstly, I hated public speaking, absolutely hated it, and it's just for anybody in the room who really hates standing in front of a crowd.

[1:06 - 1:19] I am completely trained, everything you see here is trained, I couldn't do it, I used to not be able to stand on a stage, I was so anxious about it, and I got trained to do it.

[1:19 - 1:50] And the reason that I took the training is because I think the message of what I wanted to talk about was important, and so this is the trained version of me talking about stuff, and I've ended up in this world where half the time, I'm an emergency medicine physician, in the other half, I travel the UK, Europe and the world, getting to talk about the impact of behaviour on performance, and it is the privilege of my professional career to get to do it and to be in places like this with people like you.

[1:50 - 2:11] Thank you for bringing me. This is the first time I've been in Canada for 35 years. The last time I was in Canada, I was 21 years old, and we drove a car from Toronto to Edmonton (I am quite enjoying that)

[2:11 - 2:30] We drove a car from Toronto to Edmonton, had the wildest time doing this, it was called drive away, for Canadians who don't want to drive the car across the country, you get three 21 year old Scottish men, boys really, to get in a car and do it for you.

[2:30 - 2:56] Nobody thinks that's going well, surely, you know, and it was like, it was like dumb and dumber-er, you know, it's us on the road together, but it was brilliant and I eventually end up in Vancouver for a few days, and I was stunned by what a beautiful country and beautiful city Vancouver was, and yeah, it's a complete privilege to be back here again, so thank you for inviting me.

[2:56 - 3:20] I'm going to tell some stories, and the stories are all true. If they involve people that there's any chance you would know, and I don't think there is, they'll have their names changed, so you might think you recognise the story, but it's really not the story that you recognise, and the people are impossible to identify and a lot of them are from a long time ago.

[3:20 - 3:35] I have to do a disclosure thing, I don't really have any disclosure, people pay me to come and talk, other than that, everything that I produce, everything that we produce at Civility Saves Lives is free for anybody to use in any way that they want.

[3:35 - 3:47] There is nothing commercial about it in the background, if you like this stuff, you like my slides, you can have my slides, you can use them, you don't need to give any attribution whatsoever, you can just have them.

[3:47 - 4:19] And I will send my big slide deck to people, so anybody can have any of this stuff. You can set up a commercial company and use my slides, that's cool. So there's nothing in the background, there's no hey and now I'm going to sell you the book that tells you how to do it, that doesn't exist, you've got me, you get me and me talking about this stuff, because I think it's too important to try and hide back and to try commercialise, and I think that in healthcare we kind of get that.

[4:19 - 4:50] For those who need learning objectives, there is a big, long list of learning objectives behind me. I hope that what you will get from this are some new thoughts, some different thoughts, and maybe a little bit of reinforcement of things that you already believe, it's one of the big things about how we treat each other in healthcare, and this was how it was for me, is that when people treated me or when I felt treated in a way that left me feeling diminished by it, I saw it as a personal failing…

[4:50 - 5:21] I'm too weak, what's wrong with me, why can't I function in this, then I would think to myself maybe I need to toughen up…maybe I need to be harder, I'm too soft to work around here, it turns out that I wasn't too soft, well maybe I was too soft to work in some environments, but it wasn't a personal failing, not just me it happens to, it's not just you, it's all of us, there's evidence out there and I'm going to go through

[5:21 - 5:52] that evidence as we good through that this morning. And if you go away with that, that would be enough for me, there's a bunch of other stuff in there, it's a bunch of stuff about why it really helps to listen to people's voices and tactically try and give people voice, if we want to make wise decision, we'll go through that. I have more, oh yeah, there we go, that's my disclosure, I don't know, I have no idea what people would, I could have been paid for by a pharmaceutical…

[5:52 - 6:29] company and there's a pharmaceutical company developing a civility pill, you know, maybe maybe you know, but you know, it's not true… a total aside and

forgive me, I have lots of little asides,, I was really excited that down the bottom of the road I think it's called the marijuana bean, marijuana is illegal where I come from, and I was really quite excited because I was thinking this might be the civility pill we've all been looking for, and I went down and it's closed, it's shut down, so I have no idea, I have no idea if it's a civility

[6:29 - 6:59] pill that we're looking for, I suspect not though. There we go, this is my first slide and I've always used it, and I think it's a kind of bossy statement, it's there to try to get people to think, okay, prove it, and I hope I can, but over time it's changed for me, it's changed and what I really want to talk about for this first chunk, and forgive me, this first chunk

[6:59 - 7:32] is going to be very much me stuck on send for the next hour or so, we'll change that for the rest of the day, but for the first bit this will be me mainly talking through this stuff, and we'll do questions at the end, and what's become more and more clear to me is that if we want to make good decisions, if we want to make the best decisions then we really need to be listening to other people's voices, and the key to people speaking, is treating

[7:32 - 7:44] them in a way that leaves them feeling valued and respected, but not passively doing that but actively doing that, inviting people into the conversation and making space for them within the conversation.

[7:44 - 8:14] So in a way I guess what I'm talking about is culture, so I can't see my slides, and it's really tempting to look behind me… I'm going to keep looking behind me just to check. So in a way what I am really talking about here is culture, and it’s really easy to think that our culture just gets a wee bit worse, or it's fixed, and it's tempting to see what's got worse around us.

[8:14 - 8:31] The truth is, not all things get worse, a lot of things get an awful lot better, I'm going to give you three really quick stories, they're all true, all things that two from my medical student days, and one from my mom's nursing student days.

[8:31 - 8:52] The first one is of working in a, working in a firm, a surgical firm in Edinburgh, and the surgeon who was in charge of the firm had a particularly scary reputation.. and one day he was in theatre, and this is before anybody did anything laparoscopically, so big cuts.

[8:52 - 9:19] He was a general surgeon, he was doing some abdominal operation…the senior registrar was retracting, so he's on this side retracting, but the patient's tilted in that direction, you can't see what's going on, and the surgeon's operating there, and he's retracting, and he's using his hands for some reason, and his hand slips, and slips,

and slips, surgeon pushes it back, keep it over there, slips, and slips, push it back, for God's sake, keep your hand over there.

[9:19 - 9:46] The final time it slips, the surgeon takes his hands, goes right, put it down there, leave it on the table, and surgeon turns around, takes off his gloves, puts on a fresh pair of gloves, gets a fresh scalp, will put some blade on top of it, turns around, and he stabs him straight through the hand, straight through his hand into the table.

[9:46 - 10:18] What did we say? We said that'll teach him, he won't do that again, that's what we said, and then they sent him off to casualty to be stitched up, casualty, then, and you know, you're trying to understand the culture that you're working, you're trying to understand what's acceptable and what's not acceptable, that's where your head's at, and I didn't say anything, I was

[10:18 - 10:56] scared, but I didn't say anything, and then I went off to do OBS/Gyne in a peripheral hospital, and I went to this peripheral hospital, and I went to theatre, and I the gynecologist was doing an operation, and he draped the woman for the operation, he draped her, and then he sutured the drapes to her labia with black silk, there's so much wrong there. I was 21, I was 21, and even I got this was very, very wrong, so I didn't

[10:56 - 11:29] say anything in the moment, because you've got a whole room of people here just accepting this, but afterwards I talked to the senior nurse, I talked to her. What did I get told? I got told, oh no, that's just the way he does it, that's just him, that's how he does it, and I knew it was wrong, and I tried to reason, I got told that it was just the way we did things around here, and I wasn't a stellar student, I wasn't somebody who was so good I could afford to have my head too far above the parapet,

[11:29 - 12:04] I was struggling in Obs/Gyne, and I just shut up, because I kinda done what I could, and then my mum, my mum was training, this is obviously a long time before that, and she trained to be a nurse, and she did a midwifery attachment, and then the midwifery attachment, what happened, what happened was there was a woman who was screaming in labor, she's in agony, and the midwife walked across to her, she very tenderly lifted this woman's chin

[12:04 - 12:36] up, and then she hit her across her face as hard as she could, because she didn't like the noise the woman was making. Now the point of these stories is this, I don't think there is anybody in this room who would accept any of those things anymore, I think we would all say something about it, I think we would like to believe that we would have said something back then, but I don't think we necessarily would, but I think we would now, because there's so far out the realms of acceptable that we go, that's not on, and what

[12:36 - 13:10] that is, that's our culture changing, that's us changing what is acceptable, and the thing about culture is there isn't a culture army around that corner, there aren't a whole bunch of people on big horses who are going to come in and determine what the culture is. It's just us, us, the people in this room, and culture is what we accept, it's what we don't accept, it's what we call out, what we challenge, hopefully in a compassionate way, it's what

[13:10 - 13:41] we let people know isn't okay, the only people who would change it is us. We actually change it in every interaction every time we talk to somebody, every single time we talk to somebody, we're determining what is okay, what's within the parameters of acceptable conversations, and I really like that, I think that it's an opportunity for all of us to think about what is the world we want to live in, particularly the healthcare world, and how are we going to treat people within that, and what are we going to accept and what are we not going to accept, so what

[13:41 - 14:14] I'd like to talk about for the next wee bit, weirdly isn't obviously about behavior, but it's about something different, it's complexity, and I went to talk by a guy called David Rook. David Rook has one of Harvard Business Review's top 10 ever downloaded papers about leadership, and he, I went to talk by him, he's a management consultant, he works primarily within, am I getting louder? Yeah, okay, I will trust other people to make this work, okay, and my own

[14:14 - 14:52] anxiety that I'm about to feed back and explode, I'll try and dampen that down in a wee bit, so David Rook went to this talk, and he's a management consultant, he works within ecology, and when I went to speak to him…when I went to listen to his lecture, he talks about loads of stuff, but one of the things he talked about was complexity, and he talked about it for 15 minutes, but it completely changed how I think about how we deliver healthcare, and for those that are geeks about safety, he was basically showing

[14:52 - 15:30] a version of a Stacey Diagram, but I am going to show a version of that that makes sense in my head, because Stacey Diagrams just don't work in my head at all, how close am I to be able to? Okay, so what I'm going to do in a minute is I'm going to show you, it's not really a graph, it's a straight line, and along the bottom of the straight line is how sure are we about the answer to something? And we're going to go from, thank you very much, we're going to go from being really sure to being, actually for honest, not so sure, let me just catch up on my slides.

[15:38 - 16:08] There we go, right, certainty about the solution to a problem, high certainty, low certainty… can I just check, am I incredibly loud to you guys? No, okay, it's just to me that I'm incredibly loud, that's all right…and we're going to put four boxes above it, the first box is a simple puzzle, two plus two, everybody in the room knows

what the problem is, we all know what the answer is, we can do it ourselves, that's a simple puzzle, high certainty about the solution, so we're going

[16:08 - 16:40] to have a simple puzzle, then a hard puzzle. So an example of a hard puzzle would be trigonometry, my guess is that there's not that many people in this room who can remember how to do trigonometry, that is, unless you have children of a very certain age, and you have had to prove to them that it is possible to do trigonometry by relearning how to do trig, and you know, I think I've been through a couple of times now, but this thing about trigonometry is this, if we had a brilliant

[16:40 - 17:11] teacher who spent time with us one-on-one, to talk us through the maths and getting our heads around trigonometry, we could all learn how to do trigonometry again, because there are teachers out there who are awesome, and those awesome teachers would get us to stage where we could understand trigonometry and we could do it, and then you could put us in a room with a piece of paper with 50 trigonometry questions and you could leave us alone, and we would be able to do them on our own, no help from anybody else.

[17:12 - 17:25] That's a simple puzzle, then a hard puzzle, two plus two… trigonometry, and then we go on to something different, which is complicated, you see, am I looking through yet? Am I in control yet?

[17:26 - 18:00] Okay, I'm never in control of anything in my life, this is like verging on the highlight. Okay, that's cool, okay.. complicated, see if my clicker's working, yes it is, awesome. Things change when we get to complicated, in complicated situations you might have all the skills required to do something to get the answer, but the thing is you having them on your own is not

[18:01 - 18:37] enough, because either the volume of work is so great that one person can't get through it all, or the time frame within which we have to do something is so restricted that you can't do it all, and a good example of that within healthcare is… do you know that's really triggering, that is the doorbell I had when I was a little boy at home, every time I'm thinking should I go to the door?… an example of something that's complicated is cardiac arrest, there are many of us in

[18:37 - 19:10] this room who can do every single job that is required to happen in a cardiac arrest, but if we turn up at a cardiac arrest and we are the only person there, that is a disaster, because all those things need to happen simultaneously, and one person can't manage the airway, put on the pads, do the CPR, get IV access, find the drugs, get the drugs, give the drugs, and run the thing altogether, so one person can't do it, so in this complicated situation you have to have a whole

[19:10 - 19:49] bunch of people working together, you can't do it on your own. Importantly in the complicated version of this, we're all going in the same direction, we know what it is that we're trying to achieve, the same would be true of governance, many people in the room will have governance roles, you'll know how to do lots of stuff in governance, but if you were the only person doing governance in your department or organization, it's overwhelming, so again we have to work with other people, now… then we move on to complex, and things change again in complex, it dates the talk by David

[19:49 - 20:30] Drew that when he was talking to us, he talked about the war in Syria, and what he said was in the war in Syria, lots of different people think lots of different things are the solution, many of those things…my water, thank you very much, so honestly you're so far off getting into the edge here, keep trying… It's interesting right, so this stuff going on around me, if there had been hostility

[20:30 - 21:06] within the room, if we'd come in and we'd be in disagreement with each other, I would be quite close to, I would be quite close to abreacting.., I'm in a room with a bunch of people that I've met already, I've met a lot of you already, I really like the people I've met since I've come here, these guys are utterly fantastic, so I have complete faith that nobody is sabotaging me, I have complete faith that people, well no let's get, I have no negativity bias, I know people,

[21:06 - 21:37] their reputation, which is their theme tune, is so strong with me that this could be an utter disaster, and no bit of me, no even a crack of somebody was trying to make it hard for me, would come into it…Anyhow, so when David Drew was talking about the war in Syria, what he said was lots of different people think that lots of different things are the solution, some of those solutions are diametrically opposed to each other. The reason for that is people are not going for the

[21:37 - 22:08] same outcome, they are going in different direction. The best example I can think of around this for us in health care, is when we work in our organisations and our organisations are trying to achieve things, our organisations have a finite box of stuff, finite box of resource, and our organisation might be attempting to achieve one thing, and in my world it's often the four hour

[22:08 - 22:42] target, which is an idea that you should come to the emergency department and you should be seen dealt with and discharged or admitted within four hours, so we put a lot of resources in that direction, but then our organisation has something else that it wants to achieve, say 52 week wait target for some operations, and it has to take resource from this box, what happens is we're going in this direction and we're trying our best to go in that direction, the organisation tries to achieve something else, but when it does it, it does that, and you feel it, you feel it when you're working

[22:42 - 23:14] in the system, you feel it and you think what are those muppets up to you, what is going on, because you think they're trying to make your life hard, they're actually just trying to achieve something different, and what happens when this goes on, is it creates tension, the tension that sits in here, that tension resolves itself as judgment, so we think they're muppets, sometimes hostility, sometimes outright aggression, and within the NHS in England,

[23:15 - 23:48] we have probably the best documented, best…stroke worst… documented example of that in healthcare, of probably ever, and Neil alluded to it, it's a place called Mid Staffordshire, and Midstaffes was the first of a series of NHS disasters, and in Midstaffes patients died unnecessarily, and got harmed unnecessarily, but in their hundreds, if you go and look at the

[23:48 - 24:20] data on this, and I am intimately familiar with Midstaffes, because I was the clinical lead for emergency medicine there, and in Midstaffes, and a lot of the story gets lost, but in Midstaffes, we, the doctors, the nurses, the AHPs, most of the managers, we're going in this direction, and this direction is good patient care, the best patient care we can manage to give…they, and in this particular situation, the they that we're talking about are the execs…

[24:21 - 24:55] they are going in this direction, and our execs had two things that they were trying to achieve, the first one was hitting targets that were arbitrarily set centrally, the second one was finance, they had to hit financial targets, and what happened is we went to work, but we didn't really go to work, we went to war, we went to war, and it was like the Somme, we had a trench here, we dug in, they had a trench there,

[24:55 - 25:30] we thought the execs were bastards, but we thought they thought that we were naive fools who didn't understand how the real world worked, and we went into our trenches and we went to work and we chucked crap, forwards, backwards, forwards, backwards, forwards, and backwards, and we didn't speak, we just fought, and the end result, patients suffered, died unnecessarily, it's a lot more than death happened as well, staff suffered, and people don't talk about this,

[25:30 - 26:00] when you work in an organization that falls into the spotlight of shame, it's incredibly damaging to staff, and eventually the organization got dissolved, it became so toxic that nobody would work there, and it got dissolved and split off and sort of owned by a bunch of other trusts, other hospitals that are around it now, and it would be really easy for me to finish that and go, wasn't I right, weren't the execs bastards, but that would be so unfair, because I got to know the execs

[26:00 - 26:31] really well, and you know what, they were good people, they were good people functioning in a messy system, and they were told that only two things mattered: targets and money…and it was a literal existential threat for them, because the board in

Stoke, the next hospital up the road from us, failed a financial stress test and got sacked on mass, so the execs were just people like us, with

[26:31 - 27:03] the houses, cars, bills, kids all that, nobody can afford to just be sacked like that, and what's more, they were being told they were doing a great job, so they were like, hey, we're doing a great job, everyone's telling us that we're doing fantastically well, and the way that it ended up going for us is that the culture of the place was wild, you'll find this hard to

[27:03 - 27:36] believe, but I was twice asked to stop running a cardiac arrest, not once, twice, different cardiac arrests, I was asked to stop running them, because patients in our minor stream were waiting more than four hours with their sore ankles and sore knees, and I had a manager come up to me and say, "I think it's time to let them go…", now by this time, I was a grown man, I wasn't a 21-year-old, and there's no way I was stopping running a cardiac arrest because somebody had a sore ankle,

[27:37 - 28:10] so that didn't happen, but it tells you about the environment that people were working in, where that became more important than providing care, and that's what happens

in complex systems, people pull in different directions, different things become valuable to them, and if they don't speak – it creates tension, and hostility,

[28:12 - 28:47] There we go, all right, so two questions, where do we get results in healthcare?, and how do we get credibility? And I think that's worth thinking about for a second or two, because if we think about how we get credibility, I think that for most of us in this room, we've got credibility because we are exam ninjas,

[28:48 - 29:07] we are awesome at exams, we are absolutely fantastic, going into room with a piece of paper, with 50-100 questions, each question has one right answer, a myriad of wrong answers, we go in there, deep breath, sit down, get a pencil, and we go for it, and we are bloody good at it.

[29:09 - 29:32] The thing about it though is this, if you can do it on your own, and let's face it, there are very few exams where you're encouraged to check with somebody else and have a wee convo about it, if you can do it on your own, then it is by definition, a simple puzzle or hard puzzle, and that's all about personal mastery, how good am I?

[29:35 - 30:08] The thing is, for me, the older I get, the more senior I get, when I stop and think about where I get my results, my results don't come in the simple puzzle and hard puzzle bit of it, I need to be credible, I need to know stuff, but my results, they come when I work with other people, and it is always in the complicated and complex

zone, because we have to work together, I can't do it on my own, that's all about team mastery, and it's pretty clear that the skillset required for an individual

[30:08 - 30:43] mastery, personal mastery and the skillset required for team mastery are different, crucially they are not mutually exclusive, we all know people who have personal mastery and team mastery, but most of us don't get there unless we think about it and unless we devote a little bit of time and think about why it's important and how we need to behave in order to function well within a team. There's a guy called Michael West, Michael West talks about compassionate leadership, he talks about other stuff as well, and he said something years ago that I found phenomenally

[30:43 - 31:16] difficult when I first heard it, and it's this, if you cannot do the whole thing yourself, if you can't do it all yourself, then the minimum unit of productivity is not the individual, it's the team. It's who we have on the team and how the team functions together, and I think I must have heard him say that when I just finished my final fellowship exams, and I was all about me,

[31:16 - 31:49] I was all about me and excellence in personal mastery and just knowing the answer to everything, and I found it incredibly destabilizing…this idea that I could be amazing, but it wasn't enough, because it had to be about us, it couldn't just be about me, and it took me years to get comfortable with it, and hopefully you guys are a wee bit quicker than me about getting comfortable with stuff like that, so a couple of things happen as we go to the graph,

[31:49 - 32:22] first one is pretty self-evident, increased in need for teamwork, either people need to teach us how to do things, or we need to work with other people, second one's a wee bit different, so this, this is Shulie, I'm married to Shulie. Shulie is also an emergency medicine consultant, we have very interesting conversations people love coming around the house, because yeah, we're in no way restricted in what we think about, Shulie, Shulie senior to me, she is the clinical director across two acute and two emergency medicine departments,

[32:23 - 32:54] and I have to tell you right here right now that I do not work in it, because that would be too much, you do not get to be the boss at home and at work, I'm not sure I could cope, I need a little bit of agency, and she is by her own admission, she is smarter

than me, and she's right, she's properly smart, and we share a lot of stuff, house, cars, bills, kids, that stuff, but we have stuff about us

[32:54 - 33:31] that's different… so I'm a squat, beauty, middle aged, my comprehensive educated consultant from Edinburgh, and Shulie is Welsh, she's Bangladeshi, and she's

Muslim. I'm the only non-Muslim in my family, my English family, different in Scotland, my English family everyday else is Muslim, and we had very different upbringing, I grew up in Edinburgh, she grew up in the Ronda Valley, the Ronda Valley in Wales, when she grew up in it was the most deprived area in the whole of Europe,

[33:32 - 34:04] it was an area that had been built up on mining, and it was literally the only industry there, and then the pits closed, the pits closed and there was nothing, and she grew up in the Ronda Valley, and she actually, when her parents went there to work, and her dad was a GP, when her parents went there to work, they lived in the most deprived housing estate in the most deprived area of Europe, and that's where she grew up, and it's

[34:04 - 34:41] fascinating hearing the stories of things that happened, I'll just tell you one of them really quickly, her dad got his car stolen, the car was stolen from outside the house, now Shulie is the only brown girl in the valley, yeah, there are no other people of Indian, Bangladeshi, Pakistani heritage there, but her dad's the GP, the car's gone, the next morning the car reappears with a sorry note, because people realized that someone's stolen the GP's car, and somebody

[34:41 - 35:15] somewhere got an absolute shooing for doing that, so we have very different upbringing, and here's the thing, if we're talking about the complicated and complex stuff, none of us can see it from all the angles, not possible, and what that means is that actually we need to find out how other people see something, and I don't know about you, but I've been told many times that I should, if I want to know how somebody else sees something, I should imagine it from their perspective, imagine what

[35:15 - 35:49] this looks like for them…Been told that? Imagine it from their perspective, yeah, common thing to be told, the interesting thing about it is that it's better than nothing, but that is all that it's better than. There are a couple of very elegant psychology experiments on it, but basically this is why, right, complicated or complex problem, Chris looks at it, wee squat, bearded middle age, Scottish man looks at it, so what it looks like to me, that's how I see it, but how would Shulie see it, so what I do is I mentally swing my lens around, and I go, aha, so that's how Shulie sees it,

[35:49 - 36:21] Welsh, Bangladeshi, Muslim, senior to me, smarter than me… only it's not, because what I just did was I swung my lens around, and I imagined it from her perspective, but I did that with every single one of my unconscious biases at play, because they're unconscious, I'm not aware of them, I think I'm seeing it perfectly well, and the evidence on this is that if we want to know how other people see something, we need to do two things, ask them,

[36:23 - 36:58] and silence is not asking, we need to use words that ask, and then we need to listen to the answer, but that is underpinned by something, and it's

psychological safety, and I'm only going to say one thing about psychological safety in the environment that is created that lets people speak, and it's this, you can't create psychological safety, I cannot create psychological safety, no one of us in this room can create psychological safety, we can only co-create it,

[36:59 - 37:33] I have no right to tell you that you are psychologically safe, I can't do that, you can't tell me that I'm psychologically safe…psychological safety is a relationship, and if we don't look at it as a relationship, it's incredibly difficult to create it, cocreate it, and that completely changed how I think about psychological safety when it got told that by a woman called Victoria Brasile, who is a professor of simulation in the Gold Coast. So we've got an increasing need for teamwork,

[37:34 - 38:09] but then something else happens, as we starting asking people stuff, we're going to hear things that we don't agree with, we're going to hear people have different perspectives, increasing levels of disagreement, and the crucial next question is this, how do we deal with disagreement? There's basically three different ways you can deal, first one is we can fight to win, we can decide that the important thing when we disagree with

[38:09 - 38:43] somebody else, is that we prove to them why we are right, and it's seductive, we like being right, in fact we're measured on being right, people do tests to make sure that we are always right, we really like it, we are right and we get bit of oxytocin, a bit of dopamine, oh yeah, I was right. But the thing about being right is this, proving ourselves right, it's not the same as doing the right thing, it's just proving ourselves right, it's actually

[38:43 - 39:15] dominating, because you feel like sometimes we feel like we've proven ourselves right, so all we've done is dominate somebody else, we've won. So sometimes we fight to prove that we're right, sometimes we don't like fighting, we avoid fighting, lots of us in the room will be avoidant about fighting, if you're really interested in how you deal with conflict, you can look up something in the talk called the Thomas Cullen Conflict Inventory and you can do the test to see

[39:15 - 39:51] what sort of conflict person you are, and it turns out I've done this, it turns out that I am accommodating avoidant, the sapiest of all combinations, and I have no idea how I function in emergency except I was talking to Neil about this, and also avoidant, actually most of us are avoidant, most of us just don't like fighting, it's the default position for most of us, because it feels hostile and unpleasant, and some of us have to learn how to fight, so you can be fighting to win

[39:51 - 40:25] when you disagree, you can just be avoiding the fight, or you can be doing something different, which is listening to understand, and listening to understand is the rich place, it's the place where we get better, fuller understanding of what is going on, but what happens if we do listen to understand is this we then need to be able to compromise and adapt, and compromising and adapting is actually

[40:25 - 40:57] really difficult for enough a lot of people, because it's not natural, it's not natural if you've been to a system that says you have to be right, which is what the education system does most of the time, and I see this playing out in resus, so I might have a patient who comes in, patients in resus, and they could go medically and they could go surgically, so we invite the medical registrar and surgical registrar to come down and see the patient, and sometimes they will arrive at the same time, and this is what happens almost every time,

[40:59 - 41:32] you know where this is going yeah…, so here we have a patient, medical registrar, surgical registrar, they come together and they talk about the patient for about 20 seconds, then the patient's gone, and this becomes about medical registrar versus the surgical registrar, it becomes about dominance, it becomes about winning, and the aim of the game is always to get the other person to take the patient, which if you think about it doesn't actually make sense, because if what we really wanted to do was do the right thing, there should be times when we're going to go, there's no way you should be

[41:32 - 42:04] allowed to look after this patient, this patient should be coming with us, but that's not what happens, and they go toe to toe, and they are fighting to win, and it's not until that we get senior staff, and it can be senior nurses, senior doctors, their consultants involved… that things change, and what happens is if I get their consultants to come, it's always the same, the patient gets pulled back into the conversation, and you get two people talking about a patient, and what the right thing for that

[42:04 - 42:37] patient is in the circumstances that our organisation is, so it's not the right thing for this patient on their own, it's the right thing within a system that's under pressure, almost always, and the guys have this conversation, and it always ends up the same way,

one team says okay we'll take the patient, the other team says we will come and see them every day, because they're not fighting to win, they're actually trying to do the right thing, but it's a privilege that we get when we're senior, that isn't necessarily extended to people who are a little bit more junior within

[42:37 - 43:09] the system, what we know.. is that it doesn't matter if we're talking here about at a global multinational level, or if we are talking about a resuscitation…, I'll show

you some evidence on that in a minute…, teams that share more information make better decisions, at a global multinational level, the more information that you share, and particularly if you

[43:09 - 43:44] have more diversity in your team, the bigger your profits.., for every 10% increase in diversity in your team at a global multinational level, you get about a 2% increase in your profits. 10% to 2% doesn't sound like that much of a return on investment, except for what we're talking about here, is often changing two people in your exec team, so you're hearing other things, and a 2% increase in global profits, that is highly significant to most organisations. And I like images,

[43:45 - 44:19] and so what I'd like to do, is give you an image about this stuff, so this empty swimming pool is the pool of information, and it represents a complicated or complex situation, this is by professor Joanna Gurry, professor of linguistics at Warwick Uni, Jo and I have worked on stuff for years together, this is the sort of best level I think we've got this to…so, empty swimming pool is a complicated or complex situation, can't see it all,

[44:21 - 44:54] and you walk up to it, and as you walk up to it, some water appears in the bottom, that's what you know, that's what you've brought, that's what we've brought, and we can make our decision based on that, sometimes we have to, time doesn't let us do anymore, or we can say hang on, I know I make better decisions when I have more information, and we can invite people to come and contribute, and I can invite people who look like me, but talk like me, think like me, a bunch of squat, beard, a middle-aged, Scottish men, I can invite them to come and stand around the pool of information, and there are millions of us,

[44:54 - 45:25] we are everywhere, we properly get around the planet, and we will come and we will stand around the pool of information, and we will talk about the things that matter to us, we'll talk about the patient, but we'll talk about why we think brown, warm English beer is actually quite good, and we will talk about the new wave of British heavy metal and how Saxon were criminally underrated, and that may mean nothing to you, but to us around this pool of information, will we go, yeah you're right, you know, absolutely brilliant band, and what I will do is fill the pool of

[45:25 - 45:57] information, but with the same stuff over and over, and over again, I will get a weak broth or I can choose to invite people to come and stand around the pool of information who represent difference, different sex, sexuality, race, religion, people who have different perspectives on life, but there's a bear trap there, I could get a bunch of people to stand around the pool of information who look like the United Colors in Beneton, but if they're all doctors, they all think the same way, they're all nurses, they all think the same way,

[45:58 - 46:29] it's not enough, we have to invite people to contribute who have different professional perspectives and patients and relatives where that's appropriate, and communities when we're talking about broader strategic stuff, so once we invite these people to stand around the pool of information, we have the potential for much, much richer information, and it's clearly an argument for a equality and diversity, but at this point it's the illusion of equality, diversity, and inclusivity, and the

[46:29 - 47:01] reason that it's the illusion is because every single person standing around the pool of information has their own tap, and they can choose to turn on their flow of information and they can choose to turn it off, and the single most important factor determining whether we are going to turn on our flow of information is do we feel valued and respected? If we feel valued and respected in the group, we will turn on our flow of information, if we don't, I'm turning it off, and the single most important factor determining whether we feel valued and respected when we first

[47:01 - 47:32] meet people in a professional setting, is civility, have we been seen, have we been recognized, have we been welcomed? Have people made us feel that we are a valued individual joining whatever team it is that we are joining? When we do feel valued, we turn on that flow of information, and this is true, the power of information is true even in resuscitation, so in 2015,

[47:32 - 48:05] Riskin and Erez did a seminal paper on what happens in resuscitation teams, so it's a team, so it's complicated or complex, in simulations of neonatal peri-arrests, and they found that people grade on a curve, the people grade from the terrible results to the absolutely amazing ones, the only ones we are ever really happy with. What they found was that one factor was responsible for 40 to 60% of the variance there, and for those that have seen the TED Talk, I say it's civility,

[48:05 - 48:41] but it's not, it's not actually civility if the cram things down through TED Talks, it's actually information sharing, teams that shared information made better decisions, teams that didn't share information made worse decisions, they had worse outcomes, and I mean that's kind of self-evident isn't it, you know, because if you are standing, if you're standing there, you're running a team, and you don't get told something, you can't take it into account when you're making your next decision, if you don't know it already, you can't take it into account, and the most important

[48:41 - 49:19] factor determining whether or not people shared information was civility. When teams treated each other in a civil fashion, people chose to share information, when they didn't, it reduced the amount of information people shared, and that was true, if it was a member of the team who was treating them in an uncivil fashion, it was almost as equally true, if it was a relative who was being uncivil at the side of it. What's happening here is that good teams and good team members

[49:19 - 49:39] are turning on this tap of information, that's what we do in good teams. Okay, so rudeness…incivility, if it's such a big deal, how come I went to Edinburgh medical school in the 1980s and

[49:40 - 50:10] nobody ever mentioned it. In fact, Edinburgh medical school…anybody here go to Edinburgh medical school?… okay, I can get away with saying this then. Edinburgh medical school, in the 1980s, felt to me like a dirty, great Victorian, incivility, and arrogance factory. That was what was expected, and that's what we made, and we made it on industrial scales, and then we exported it mainly to England, which we seeded very nicely with it. Now I don't think Edinburgh is that different other places, but it was

[50:10 - 50:38] a place that I went to, and treating people poorly seemed to be just the standard, that's how we did it. I did my membership in surgery, and then I did my membership in emergency medicine, and nobody mentioned how we treated each other, and then I did my fellowship in emergency medicine and in six years, not once, not once did we talk about the impact that we have on each other.

[50:39 - 51:08] And there's a really good reason for it. We didn't know. Between 1996 and 2001 and the whole of academia, there were only 23 papers on the impact of behaviour on performance. 23 papers just disappears. You don't see them. Between 2011 and 2016, there were 1700. 1700 papers on the impact of behaviour on performance, and they pretty much all say exactly the same thing.

[51:09 - 51:31] Behaviour matters. Civility matters. But I should check, have you guys see rudeness around here, maybe to you, maybe someone's been rude to you, maybe you've

witnessed in civility between two other people. Maybe it's been by you. It's certainly been by me far too many times.

[51:34 - 51:45] Take a second and just think about when somebody was uncivil to you. For some of us, we might need to think back a few years because it happens less often when you become senior.

[51:47 - 52:19] What did it feel like when somebody treated you in a way that felt disrespectful? I'm not talking here about somebody screaming and shouting at you necessarily. The sort of work that's done on this is not on screaming and shouting. If you have a workplace where it is normalised to scream and shout, you have a toxic workplace. If, on the other hand, you have a workplace and somebody screams and shouts, and the response of the people that you work with is for somebody to go and check in on them

[52:19 - 52:45] and make sure they're okay, then you don't have a toxic workplace. We have a very difficult workplace and occasionally people break a wee bit. But our response determines whether it's toxic or not… whether it's acceptable or not. The sort of stuff I'm talking about here is mild to moderate incivility when people treat us in ways that just feel really uncomfortable and we think they might be trying to hurt us.

[52:47 - 53:04] How does it feel when somebody treats you in those disrespectful ways? Because I think for a lot of us, we end up feeling angry. We feel angry, how dare you? How dare you treat me like this?

[53:05 - 53:36] The interesting thing about the research on this is that's not where we start. In the moment when somebody treats us in an uncivil way, we don't feel angry, we feel belittled, we feel ashamed. Shame is so powerful. We're probably ashamed because we're not doing something about it. Really powerful inhibitor. We feel humiliated. We feel powerless and we feel childlike and then gradually sometimes over seconds, sometimes minutes, sometimes hours, days, weeks,

[53:36 - 54:11] months, even years, we make sense of it. We get that place where we think about it and we go, how dare you? How dare you treat me like that when I was just trying to do my best? And you treat me like that? That's not where we start. We start in the belittled ashamed humiliated part. Then you can think of this. Think of this like the wedge of threat and the wedge of threat goes from the thick end where there's somebody about to do something horrible, a clear and present

[54:11 - 54:44] danger, somebody pulling a knife out their pocket in front of you. You should become adrenalized, you should become very aware of the danger and you should be getting ready to do whatever you need to do. But the other end of the wedge of threat is the stuff that's hard to tell if it's meant to be offensive or not, but it's definitely uncomfortable. The people who tut when you're speaking, the people who rolled their eyes when you say something, the people who finish your

[54:44 - 55:15] sentence off for you when they couldn't possibly know what the end of your sentence was, or the people who correct your grammar halfway through a sentence when that means they're listening to criticize rather than listening to understand what it is that you're trying to say. And they're uncomfortable and we're not quite sure if people are trying to hurt us but it triggers response in us and it triggers a physiological and psychological response. The physiological response is we start

[55:15 - 55:46] to shunt a tiny bit of blood from our brains to our body but the psychological response is we start thinking differently. We think less well and what thinking we have left is orientated towards more hostile things. So we start thinking of the bad stuff that we might need to do in this given situation and there is reason for

that… it's evolution, it's us going to hang in a second. If you treat me this way, what's next? What comes next? What are you prepared to do to me?

[55:46 - 56:21] If you're prepared to disrespect me at this level, are you going to get worse and worse? And we have to get ready for what might happen. And you can measure it. You can measure the impact all that this has on people. So the recipient in the moment, in the moment the recipient has a reduction in their intellectual capacity, 61%, squeezes your bandwidth and you just can't think that well. And it has all sorts of consequences. One of them, the one that feels most important in terms

[56:21 - 56:55] of teams, it's not the personally most irritating one but the one that's important in terms of teams is this. If I have a team around me and I treat those guys in a way that leaves them feeling disrespected, what I'm doing is two things. The first thing is a squeeze of bandwidth, they're less smart and they're not thinking so creatively. The second thing is this, they're turning off their flow of information. And now I've got a bunch of people around me who aren't thinking as well as they could be and who are less likely to speak up. And if they do speak up, I get a less

[56:55 - 57:29] smart version of them. This is a disaster for the teams that we work in because we're effectively starving ourselves of the oxygen of good decisions, which is information. It also explains why you know when somebody you meet somebody and they treat you in a way and you think what the hell was that and you walk away from it and you go to your office or whatever and you're sitting down you think, what happened there? You're sitting, you're trying to do some work and you try to push out your head and then it comes back again. And you have to push out your head again and it's back again

[57:29 - 57:48] and it's really, it's got its talons inand it's got a name, it's called emotional hooking. And when that happens to us, it's really frustrating but we get through our day, we finish our day, we go home and you're sitting in the car in the way home and you don't think you're thinking about anything. And you have that little moment when you go boom, that's what I should have said.

[57:49 - 58:27] I should have said that. If I said that and I'm sitting in the lights and I'm really hacked off myself because I'm sitting in the lights, I'm going, you know what? If I said that right there right then they would know that I am not the sort of person to treat like that. They would know that I'm a wet. They would know that I am a really funny guy and I would have, I would have gotten just to stop doing that there and then. The truth is in the moment when somebody treats us that way, we're not the wonderful witty people that we can be. In the moment we are literally diminished intellectually and we can't think of that witty thing. Has impact on other people as well,

[58:27 - 58:58] oh, by the way, by the way, just thinking back to those people, I think all of us have worked with people who are, I think all of us have worked with people who behaved that way, who diminish the team around them. I have to say, I don't think that any of them are deliberately doing that. I think what's happening is that a whole bunch of people grew up in an environment like I did where leadership appeared to be belittling people and dominating people and never

[58:58 - 59:20] showing any weakness and I think we brought it into our leadership style. We live what we learn and we brought it into our leadership style when we were more senior and in my experience when you talk to people about this, if people recognize themselves in this, they simply stop doing it.

[59:20 - 59:54] You don't come to work to diminish the people around them. We of course think that that's what their purpose is, that we think they're deliberately doing it. But they are not. They're just role-modeling what was role-modeled to them and just talking about this stuff, drives behavior changes and there's really nice evidence on that that some people are self aware enough to go, oh, okay, maybe I don't do that again. There's an impact on on on-lookers. It used to be thought there wasn't an impact on on-lookers and then a whole bunch of people looked at it and it turns out that on average just

[59:54 - 1:00:18] witnessing and civility results in a 20% reduction in our cognitive ability. That's not directed at us, it's just two people having an uncivil interaction. But that is not evenly distributed. If you look at people and look at where they sit on the empathy spectrum, this is worked by Gadi Golan, looking at work by Simon Baron Cohen. There's a spectrum to empathy.

[1:00:18 - 1:00:40] There are really empathic people up this end of the spectrum and down this end, the cold fish. The really cold fish – you know this because you know that you've met them. It turns out and this won't surprise you that if you're at the top end of the empathy spectrum and you witness incivility between other people, it has a greater detrimental impact on you than if you're at the bottom end of the empathy spectrum, if you are a cold fish.

[1:00:42 - 1:01:13] And that is crucially important to us because who do we want to work in healthcare? We want people up this end of the spectrum. We want empathic people because empathy is a very close bedfellow of compassion, in fact, is a component of compassion. Compassion is empathy combined with kindness. It's recognizing other people's feelings, usually pain, and then doing something about it. So we want these guys to work in healthcare. We want them to work in healthcare

[1:01:13 - 1:01:38] because compassionate care is an independent predictor across every patient outcome, from compliance to wound healing, to how much pain we feel. Compassion is an independent predictor of patients getting better, quicker and feeling less pain. I'll just tell you a really quick study on this. There's loads – there's this lovely book called Compassionomics about it.

[1:01:39 - 1:02:12] But if patients are randomized before a major abdominal operation to standard nursing care or compassionate nursing care, most nursing care is compassionate, but the explicitly compassionate nursing care side took 40 seconds longer. The patients who are randomized to the compassionate nursing care side, post-operatively used 50% less opiates in their PCA (patient controlled analgesia) because when we feel like

[1:02:12 - 1:02:43] people care for us, we feel less pain. This is why we cuddle our kids. It's innate but it's why we bring people in, we look after them when they're hurting because it reduces pain and it literally reduces pain in patients post-operatively. We need it as kids, but we need it as adults as well, and we need it when we're in pain and it reduces our pain. One other really quite thing is we've known since the 1970s in emergency medicine that if we treat people who come back time and time

[1:02:43 - 1:03:07] again, there's sometimes referred to as frequent flyers, and they irritate staff, but if we treat them badly, they keep coming back. If we treat them really well, they come back one third less often. Treating people well is really good for them. When I start doing emergency medicine, we used to pump people stomachs out to teach them a lesson. Well, that wasn't working.

[1:03:08 - 1:03:41] Literally, I've been told that, you know, we teach them a lesson by pumping their stomach out. It just doesn't work…Okay…but there's something else that happens. There's something else that happens when when we witness other people being uncivil to each other. It makes us less kind. If you… if you witness, Deema, don't worry, I'm going to, you're going to hear your name and you're

[1:03:41 - 1:03:56] going to think you have to do something. You don't need to do anything. If you witness Deema and me having an interaction that looks uncivil to you, you would be primed by that. If you then got up and went around the corner and somebody asked you for help, you're 50% less likely to help that person.

[1:03:58 - 1:04:24] This stuff is literally contagious. Fortunately, so is the good stuff. There's one group of people who are more likely to be uncivil than anybody else. And they do not all look like this. It’s bosses, people in positions of authority. Something happens to us when we become bosses.

[1:04:25 - 1:04:52] Paul Pith and Daker Keltner look at this...so do a bunch of other folks. But when we become bosses, we change. When we become bosses, we're three times more likely to sit in a meeting using our phone or computer for something other than that meeting. We're three times more likely to interrupt people. Three times more likely to raise our voices at them. And the people who become bosses did not display those behaviors before they became a boss. They checked for this.

[1:04:54 - 1:05:27] I used to think that what was happening was that you became a boss and then you treated it as the right to behave as you like. But I don't think that's right. I don't think that's what's going on at all. I think that for an awful lot of us, when we become bosses, we move up a level and we thought that we knew what the next job was. We thought we'd been trained for this and we move up the next level. And what we're actually confronted with is an alien landscape. It's completely different. The old job kind of pokes up into a wee bit. But then there's governance.

[1:05:27 - 1:05:41] There's business case. There's accountability corner. I still don't really understand what accountability means. It seems to mean whatever people want to make it when they want to give you a hard time about something. And this all exists and you're looking at it and you're lost.

[1:05:42 - 1:05:59] And we get impostor syndrome. And we're uncomfortable. We thought we were meant to know how to do this. We thought we'd hit the ground running but it's an alien landscape. And what we do is we move into command and control because we want to feel grounded. We want to feel like we know what's going on.

[1:05:59 - 1:06:25] We move into command and control. We try and get some grip. One of the places where we can feel grounded is in the job we used to do. So we kind of dip back into that a little. We dip back into a little bit because it makes us feel like we're still useful. But if you've ever been in a job or somebody's been promoted and then they keep dipping back into the bit of the job that you're now doing, it's deeply uncomfortable and you feel like you're being micromanaged.

[1:06:25 - 1:06:49] They're not really micromanaging. What they're doing is they're trying to stabilize themselves because they're so uncomfortable in the new job. And that move into command and control is interesting because command and control in complicated and complex situations is proven to be the worst form of leadership for getting the best results. And that's Michael West’s work.

[1:06:50 - 1:07:14] But what's really important from my perspective is that for people who are in people who are in leadership roles, those that go on to be regarded as being wise do not stay in command and control. They move from command and control to a different mode of leadership, which is called asking not telling. And what I research is the development of wisdom.

[1:07:14 - 1:07:47] And wisdom is really fascinating. If you ask medical students what wise looks like it's people who know they answer, people who just know lots of facts and stuff. By the time you get sort of senior levels, you ask people what wise looks like. They talk about the decisions that people get to. But then if you interrogate them as to how they got there, it becomes about the people who ask other people for their opinions, people who start to fill that pool of information. People who don't think they've got all the answers. If you belong to the group of people, and from the

[1:07:49 - 1:08:24] conversations I've had, I suspect this would be a lot of people in this room. If you belong to the group of people think that Donald Trump might not be a particularly wise man. One of the reasons why people tend to think he's not a particularly wise man is because he thinks he has the answers to everything. When he got asked about foreign policy, he got asked who you're going to go to for advice about foreign policy. Now most of us get that foreign policy is a big old deal. His reply was “myself. I'm a very clever guy”. Literally, that's a quote. That's what he said. And I think that we

[1:08:24 - 1:08:55] would recognize that generally people that we see as wise within health care are people who are listening to other people and giving other people voice. And it's determined how we give people voice is really fascinating. You can give people voice by saying, hey, what do you think? But if you say to somebody, what do you think, what they tend to do is tell you what they feel – a hot take - the first thing that comes to their head. If you ask a better question, you get a different answer.

[1:08:55 - 1:09:33] And a better question is - this only works one on one. It doesn't work in a group. It feels wrong in a group in most cultures. A better question is this. So, Deema, can I get the benefit of your wisdom on this? What that does is it triggers a different way of thinking. It's not, hey, this is what I think. The benefit of your wisdom is something that people go way and think about. They give it time and they come back. And asking, not telling seems to be the route to getting to the best answers.

[1:09:33 - 1:10:08] Because what we're doing in leadership positions is that we are using our wonderful experience leadership brains to synthesize the best answer from the best information. And we don't have all the best information in the first place ourselves. Okay..I'll wrap this. Sorry, I just had it out. We thought I wasn't sure if the next slide was there. There's a story. I'll probably tell you later on. It might be a complete dick. It's a hideous story. And the reason

[1:10:08 - 1:10:30] the story is there is because we all get this wrong sometimes. Everybody in this room will get this wrong sometimes. We won’t mean to, we'll just get it wrong. And that when we do, it's about what we do with ourselves once we get it wrong

and how we try and make it better. I'm going to talk about that later on, I think. Let's pull it together. So, it's probably my favourite picture

[1:10:31 - 1:11:06] This is 1959. It's the Western General Hospital in Edinburgh. The NHS, the system I work in, is 11 years old at this point. And that's my mum. On my mum's right is Julie and my mum's left is Charlotte. Charlotte ended up living in Vancouver Island and working as a nurse there. And my mum in Charlotte and Julie trained together. And they have that bond that we have of working with people and seeing the best and worst of other people's lives and trying to care for them. And they remained

[1:11:06 - 1:11:37] friends their whole life. So when I first started giving this talk, Charlotte and Julie were both still alive. Julie died four years ago and Charlotte died a couple of years ago. But when Charlotte came back from Canada, my mum and Charlotte and Julie were still meeting up and having coffee together. It's just a lovely thing. My mum is still alive and kicked. And my mum is 85 years old and single handedly keeping Marks and Spencer's alive in Edinburgh. She's still shops like she has three kids at home,

[1:11:37 - 1:12:12] you know. And a couple of weeks ago she told me that she told me that she's thinking about getting in a car and driving in Edinburgh is not like driving around here. It's like, oh my goodness, that horror moment of your 85-year-old parent talking about getting a new car. Anyway, so back in 1959, twice a day it was my mum's job and Charlotte and Julie's to clean the ash trays, one of which was built into everybody's bedside cabinet. But when I went to medical school the holes for the ash trays were still there. We thought there were for vases which had been banned by that point, you know. But

[1:12:12 - 1:12:22] actually they were the holes for the ash trays. And twice a day, my mum would clean them and put them back out. Again, patients would lie in their beds smoking. You could buy asthma cigarettes.

[1:12:23 - 1:12:37] You can see them online. And doctors would tell patients that smoking was good for the nerves. And I like to think that my mum would come up behind me saying, do you smoke? I like to try one.

[1:12:38 - 1:13:11] And she hates it when I say that. It's probably the only thing in this that's not true. But I'll tell you why I tell that story. You know how you trust your parents…You're meant to trust your parents. I'm a really keen gardener. And my mum used to stand at the back door when she smoked and she stopped smoking at five or six. She would stand at the back door and she'd smoke…and then she'd finish her

cigarette and she would flick it in the back garden. It's just so not my mum. It's not how she would normally behave anyway. She used to flick it into the back garden. And I remember asking her why she flicked it in the back garden. She said, good for the

[1:13:11 - 1:13:42] plants. And I just incorporated that piece of information into my head. And I'm a really keen gardener I was in my forties before it occurred to me that telling my mates to flick their butts into the back garden because it was good for the plants was actually probably not true. So that's me having getting my mum back in my mum about that. But then what happened? Well, Professor Daw came along we discovered the terrible toll that tobacco takes on health. Really rapidly a lot of people stop smoking within health care and gradually end over time and with different levers, smoking has become

[1:13:42 - 1:14:14] rarer and rarer and rarer. Until now it's actually vanishingly rare to see people smoking compared to when I was growing up. So now it's 2024. We're beginning to understand the impact that behavior has on each other. And it is relatively new information. And that's great, because it's a wonderful opportunity..because by choosing to behave in ways that value and respect other people we have an opportunity

[1:14:14 - 1:14:44] to help people to perform at their best. When we do that within teams and we create environments where people share more information what happens is we get better outcomes. We get better outcomes for patients. We actually get better outcomes for staff and we even get better outcomes for organisations and I can show you some of the evidence on that later, if you would like. In other words, civility saves lives. Thank you for listening to that but the rest will be much more interactive.

[1:14:44 - 1:14:47] Time for a break.