



Transcript: Podcast #341 – Dr. Rob Hackett on the #TheatreCapChallenge & Change in Healthcare

My guest for [Episode #341](#) of the podcast is [Dr. Rob Hackett](#), an anesthesiologist in Sydney, Australia. Rob has become known around the world for his role in what's now called the “[Theatre Cap Challenge](#)” — a method for improving communication and, thereby, improving patient safety and outcomes.

As we talk about today, Rob had the idea of writing his name and role on his surgical cap with a sharpie. Eventually, he (and others) have gotten printed caps made as shown below in [my LinkedIn post](#) about our discussion (it has received 200,000 views and counting).



Mark Graban 
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1h · Edited

Recently, I interviewed Dr. [Robert Hackett](#), a British anesthesiologist (in Australia) who had the brilliant idea of writing his name and role on his surgical cap to improve communication amongst the surgical team in the operating room (and better communication is proven to save lives).

Putting that information on your forehead makes it more accessible when needed compared to an ID badge that's covered up or a whiteboard that's out of sight.

The podcast will be released in a week or so (update: see link at the bottom of the post). Look online for the hashtag [#theatrechallenge](#) for examples and photos.


We had a fascinating and at times, discouraging conversation about how there can be such strong resistance to such a simple idea. People ask for evidence but then also reject the idea outright (meaning evidence can't be collected).

Dr. Hackett, a tenured physician, says he has been bullied and had his career threatened. Is that "making patient safety our top priority?"

Has your hospital adopted this practice? Would you? Why not?
[#patientsafety](#) [#healthcare](#) [#leadership](#) [#change](#)

More information: <https://lnkd.in/e69Mtyp>

Our podcast: <https://lnkd.in/emN2hcK>



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In honor of Rob and the Theatre Cap Challenge, I have a temporary logo for the podcast, at left, with my own photoshopped cap.

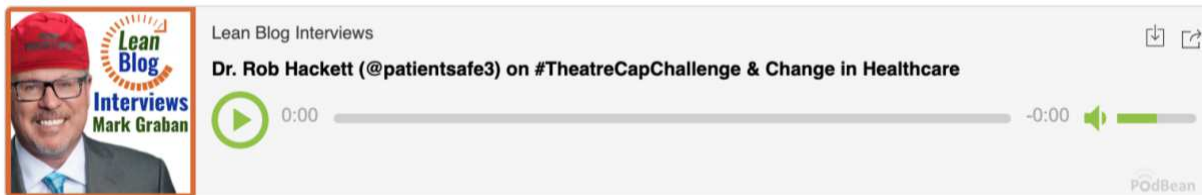
As I wrote on LinkedIn, Rob has, unfortunately, been trolled, threatened, and bullied for this seemingly benign and obvious improvement idea — both in the workplace and online. It seems that outsiders to healthcare and those who are new to medicine find an idea like this to be obviously helpful, but those who have been in healthcare the longest struggle to accept it.

I appreciate Rob's perspective that those who oppose this innovation, for whatever reason, probably aren't bad people — they just have a different view and, possibly,

some old habits or cognitive biases that they are stuck in.

The interview goes for over an hour. One thing I'd like to do is produce a shorter audio piece that's more like an NPR news story. His website is www.psnetwork.org.

Listen to the podcast: www.LeanBlog.org/341



Transcript:

Mark Graban: [03:00] We're joined today by, again, Dr. Rob Hackett. Rob, thank you so much for joining us.

Dr. Rob Hackett: [03:06] Thank you, Mark. Good morning from Australia.

Mark: [03:08] [laughs] I appreciate you being up so early before your day's work to have the conversation here. Can you introduce yourself, talk a little bit about your professional background, your career in medicine to help set some perspective?

Dr. Hackett: [03:24] Mark, I'm from the UK originally near Liverpool, so grew up in the NHS, studied in medicine in Sheffield, did my first year as a house officer in Sheffield in the UK. Then, came over to Australia for what was supposed to be a year. That was back in '98. I met my now wife after about two weeks and ended up staying. Then, started a career in anesthetics in the start of 2000.

[03:58] My work now is based around Sydney. I work in eight different hospitals. One's a major public hospital in Sydney, and seven private hospitals of different sizes. I have no formal training whatsoever in ergonomics. We use the term ergonomics from now. I'm trying to avoid the term human factors.

[04:23] My fascination for patient safety started probably around 2008 after going to a very upsetting death of a young lady who happened to be the daughter of a theatre nurse. She'd had a baby herself three months earlier. She died from air embolism, from a central line being inserted.

[04:49] Everyone involved in her resuscitation knew her personally. After an hour of trying, we never got it back. It's a pretty high motivation and driver in my life.

[04:59] The other thing is, as a junior, or as a fellow towards the end of my training, breaking down the door of a colleague who'd taken her own life as well -- took an overdose of propofol. Those things motivate me. They drive me. They are certainly there in the background.

[05:26] Being exposed to some presentations by some people like Terry Fairbanks, who works for MedStar. He's a system safety expert. He says the quickest way to become psychotic is to understand system safety and then go and work in healthcare. I can completely appreciate where he's coming from.

[05:48] That was probably back in 2015. Since then, I've just been getting myself in more and more trouble but, at the same time, learning more about how to drive change in the industry. I'm able to fall back on and interact with so many people from all over the world who [inaudible], and selling me with new ideas and new thoughts.

[06:18] I certainly feel that I can see a completely different way forward for healthcare. We're really at an embryonic stage of a healthcare that does become a lot more efficient and works in the favor of our patients.

[06:39] At the moment, we have a frontline where the environment only becomes more complex every day. The more complex it is, the greater risk of error. With those errors, then we're in trouble.

[06:56] The other motivation is from trying to introduce the safety change, probably about four years ago now, and pushing it hard, and eventually being pulled into a room and having my career and my livelihood threatened.

[07:17] Then, the realization that, as a senior consultant anesthetist at that stage, that individually, we don't really stand a chance trying to introduce the changes that need to happen for ergonomic science to be introduced into the industry. We really need to work together as a team. Thanks, Mark.

Mark: [07:46] Before talking about some of the solutions, and including the theatre cap idea that you've had, can we talk a little bit about some of the causes in the lean methodology, we try to make sure we understand the problem, the scope of the problem and the causes?

[08:04] Can you talk about, from the data and things that you've seen, some of the primary causes, including miscommunication? What does that lead to?

Dr. Hackett: [08:18] There is good data that 70 percent of errors are due to communication problems. I suppose I tend to see things differently. I don't tend to look so much at what caused this issue, what I'm looking at is how can we improve? How can we improve?

[08:41] I just look at the environment that I'm in and look at the inefficiencies, the bad equipment, the poorly designed equipment, the poorly designed systems that surround us. How can we simplify those things? How can we standardize those things?

[09:00] We work in a highly policy-driven industry. Every department in every hospital may even have five or six revisions of the same policy government telling us how to do our jobs properly. That is just insane.

[09:25] It's like driving around in every town or every road that you drive down has a different set of road rules. It's completely bonkers. That's the best we seem to be doing at the moment in healthcare.

[09:44] To try and push back against that is really, really difficult because it comes from the top down ingrained thinking amongst all of us in the industry that this is how safety is done. Unfortunately, we are resistant to hearing things from elsewhere. There is a whole scientific discipline yet to be introduced into the industry.

[10:07] As far as looking at what leads to those mistakes, it's not so much focusing backwards. It's looking forwards at what can we improve. What can we improve when you open your eyes to this? It does drive you mad because I'm surrounded in many of my hospitals by bad design that I know is killing people.

[10:41] An example, I take it to those levels is the oxygen cylinders that we're currently utilizing in pretty much all the hospitals internationally. In the UK, there were six reported deaths and 400 near misses just because of the design of these oxygen cylinders.

[11:04] Four or five things that suggest to you that the oxygen cylinder is turned on, even when it's turned off. You can even hear a hiss of gas coming out of the cylinder reassuring you that it's turned on when it's actually turned off.

Mark: [11:22] Yikes!

Dr. Hackett: [11:23] We're well aware of this design issue, yet we do not have an industry that can remove that issue. In aviation, they've obviously just grounded some of the Boeing planes. These oxygen cylinders will have killed way more people than the Boeing planes. We can't do anything about it and push on an individual level to try and change that. You will be taken out.

Mark: [11:53] It's sad to hear. We can talk more about that, more in the context of the theatre caps. Maybe, when we transition to that of the idea that you had where the spark of it was. It's a visual [laughs] solution.

[12:12] I'll put pictures on the blog post for the episode. Let's walk through. I'll let you tell the story of what this seemingly simple, innovative practice is here.

Dr. Hackett: [12:25] It was, obviously, the ergonomics thinking, but it was sparked by the event where I was brought into this room trying to introduce another obvious safety change.

[12:43] I sent out a survey. 48 out of 50 of my colleagues wanted that safety change. None of them are prepared to stand up and push for it. I presented all of the evidence in a cost-beneficial way, but it just wouldn't happen. Then I was brought into this room eventually, the CEO of the hospital, the head of my department, and the head of critical care, for an hour.

[13:16] I had a support person there with me. I was suspicious that something like this might happen, so I'd, luckily, taken someone with me. For an hour, I was attacked -- verbally attacked. At one point, the head of critical care department looked me in the face, pointed at me, and he said, "I don't care who you are or what you do. If you do anything like this, again, you are out."

[13:40] I was like, "Wow." I walked out of that meeting and I thought, "Wow, this is a real worry. Here I am, a senior consultant anesthetist, going to drive change, obviously benefit patient care, and they will go to these levels to maintain the status quo. What do you do?"

[14:02] It was like a year of deep thinking, deep learning. Had to read more, find out more about myself. There was a book that I always wanted to read, but never really wanted to read because of the title, Dale Carnegie's book, "How to Win Friends and Influence People." It's an awful title to a book, but it just made a lot of sense. It's over 100 years old.

[14:26] There's a whole chapter in there on the importance of names. It also dawned on me that we do have this checklist from Atul Gawande. It's 's very poorly performed. In many hospitals, there is a tick box on there. It's probably the most poorly performed part of the actual form, which says all staff members introduce themselves to one another by name and role.

[14:54] Hospitals throughout the world will be ticking this box, and the actual procedure is not performed. It's been brought into a culture that's not used to it. Despite that, I'm really struggling to remember the names of people. We'll be going to these arrest situations. There I am, coordinating 40 people whose name and role I just don't know. I know it's an inefficient thing. I know patients will benefit a lot more if I am able to coordinate it better.

[15:27] I was literally just running to work one day. That's when it dawned on me, we have to write our role on our hat, because it's the last place that we've really got. It's the last bit of real estate.

[15:44] Don Norman's, *The Design of Everyday Things*, it's another book that's influenced me. You have to design things based on the constraints of your environment. The constraint of our environment in theatre is that we cover our tops with sterile and warm gowns, lanyards are put down tops. Any badges that are on your top, they just become covered up.

[16:13] Visually, the people that are around us everywhere, you can't see their name and role on that person. There's actually even a policy that we're supposed to do this. When I thought about it, it became more and more obvious. The thing that was also in the back of my mind was I knew the resistance that there would be to it.

[16:37] It's like here is something that's obviously better for patient care. The patients are going to be able to see this. Everyone will be able to see this. What they'll also be able to see is the resistance that comes to it despite it being better for patient care.

[16:53] Patients will start to realize that healthcare is not aligned with their best interest. It will be a huge advertisement for the safety movement and ergonomics in itself. That is why out of all the projects push, I push this very, very strongly. I see it as a huge advertisement of a different way to go.

[17:17] It's been brilliant. I know the way that we work as a team of teams, because of social media and social networks, we've got an 80 strong team with professors of communication, Theodore [inaudible] pitches in every now and then. He's got the OR black box video recorded in theatres. We've got all sorts of people from all sorts of walks of life.

[17:47] Working in this way as a huge collaborative team gives us a lot of stamina. There are people generating data points from lots of different hospitals throughout the world and just sending in. We put it in one place and then sending it back out to everyone in the world and say, "Look, have a look at this. Read this. Read this new bit of data."

[18:09] Just recently, we've received a \$30,000 grant to run some simulation and other assessments. For me, at times, I step outside the box and think, "This is absolutely insane that we have to go to this level to show people something that is so bleedingly obvious."

[18:32] Unfortunately, that is the nature of healthcare and how we've been conditioned over the years. You have to show the evidence. You have to show the evidence. Show the evidence that displaying your name and role makes it easier for people to understand your name and role? How ridiculous are we? Come on, let's move on.

[18:56] It sends a message to people, it's not evidence that you need. It's something else, something else that's going to tick your buttons on a personal level, and allow you to introduce this change.

[19:10] One of the other massive drivers that we'll see is the more people do it, the more other people will become comfortable in doing it. It almost becomes a viral phenomenon, and a huge advert for ergonomics and the introduction of ergonomics into healthcare.

[19:31] It's been great because it's allowed me to interact with people like yourself, Mark, as well. These interactions is where I see it out. I sense your frustrations as well, at times, and a lot of others' frustrations with an industry that is resisting these changes to the detriment of all of us.

[19:56] Everyone wants patient safety to improve. The more that we start to move in this right direction, the more people will become comfortable with it, the more it will become mainstream, the more it'll become the norm, and the more that we'll all benefit. It takes a lot of constant agitation from a bigger and increasing group. We will get there. Yeah, we will get there.

Mark: [20:28] It's mind-boggling. I'm trying to figure out even how to ask the question. The idea is as simple and important and seemingly effective an idea -- putting your name and your role on your head so everybody can see it and not have to walk to the whiteboard.

[20:47] As you've laid out the case that knowing people's names helps improve communication, which helps reduce errors, which saves lives. How could people be opposed to this? I'm curious to be told very specific examples of the first time you did this, what were some of the negative responses about what you were doing or what you were trying to encourage others...?

Dr. Hackett: [21:17] I knew they would come. They still do come. They come in droves. I'm threatened legally. I've been bullied, intimidated. I'm trolled on social media. I knew it's there. The other great thing is it exposes this culture for others to see so other people can see how bad these things are.

[21:41] One of the surveys that we're about to publish, over 1,000 people, demonstrates there's a lot of support of it for the initiative. Patients, in particular, 92 percent, they completely support it. They want us to do it. Front-line staff, 86.5 percent.

[22:06] When you look at those that are new to healthcare, they're nursing and medical students, it's almost unanimous. It's 100 percent of them want to do it. The support is least from those who've been in healthcare the longest. Even then, it only dropped down to 55 percent.

[22:27] Perhaps, that's where you start to see a big issue is these are the people with the greatest influence. When you work in command structures as we do in healthcare, that influence can be particularly strong. Within one of my hospitals, I am still not allowed to even present on the initiative.

[22:50] The other great thing about the initiative is it's been able to narrow it down to a specific individual who is so vehemently resistant to the idea and intimidatory in his behavior. He's surrounded by a group of people who are reticent to approach him, from below and above, because they see their careers will then be under threat as well.

[23:18] The managers above him are fearful of approaching it even just as much as the people below. This one individual is able to drive a whole culture throughout a whole [inaudible] complex. It's not just for this one initiative. It's for lots of other things.

[23:38] One of the things that strikes me is this idea of cognitive dissonance. If you accept change then you have to accept that what you were doing before wasn't as good. We work in a very emotive profession. People die at our hands.

[23:55] How dare you say that we weren't doing things well enough? How dare you say that? It's very, very, very offensive. It is. We resist change. We put up every possible obstacle that we can in resisting it. Things that are thrown up are, "Yeah, it's going to cost." Then you show them it'll cost less.

[24:20] It's actually beneficial for the environment, the Caps Initiative. One of my bigger hospitals will dispose 100,000 disposable caps a year. They're made from viscose. They're really detrimental to the environment. Other things that are thrown out there, infection control.

[24:41] The actual infection control group or specialty are so upset that they are often used as a barrier to resist change. They've published in a lot of their articles that the only benefit of theatre hats is in stopping the shed of hair. That's it. You don't need to put a disposable cap on all the time.

[25:17] It, today, enters policies blah-blah-blah. Then you try and push back against those policies. It's really, really, really hard. Every single obstacle is put in the way. Then it's, "Oh, you've got to show the evidence before this can be brought in as well." There's another obstacle there. All of these obstacles are put in the way.

[25:40] When you've got past all of those, it turns to threats, intimidation, ostracization, bullying, all of these things are seen. They can all be applied to any of these ergonomics initiatives as you try to bring them in. The cap helps expose them for what they are. The other great thing about the caps is they've got such a visual nature.

[26:12] When you get into an environment where people are wearing them you feel a lot more comfortable as an individual to wear them. The other thing is it starts to expose those hospitals, those institutions that have a progressive, forward-thinking, patient-centered, patient-minded thinking.

[26:34] Gloucester Hospital in the UK, for example, they've just gone and bought name-and-role caps for all of their staff. We're working on a map at the moment as well of all the hospitals that have introduced The Theatre Cap Challenge initiative at some degree within their hospital.

[26:57] There's a lot of support in the NHS in the UK. They've got a very quality-driven, quality-minded culture. They may well lead the way on this. It's also nice in some of my hospitals, we have started to take the initiative on as well. I think we'll see more and more with time.

[27:23] I do like this idea of impacting on institutions' reputation to help drive change. That's really what we are ultimately going to have to do as a general group, as a general public. Allow the public

to know that the hospital that they're walking into has a patient-focused, patient-centered culture and thinking.

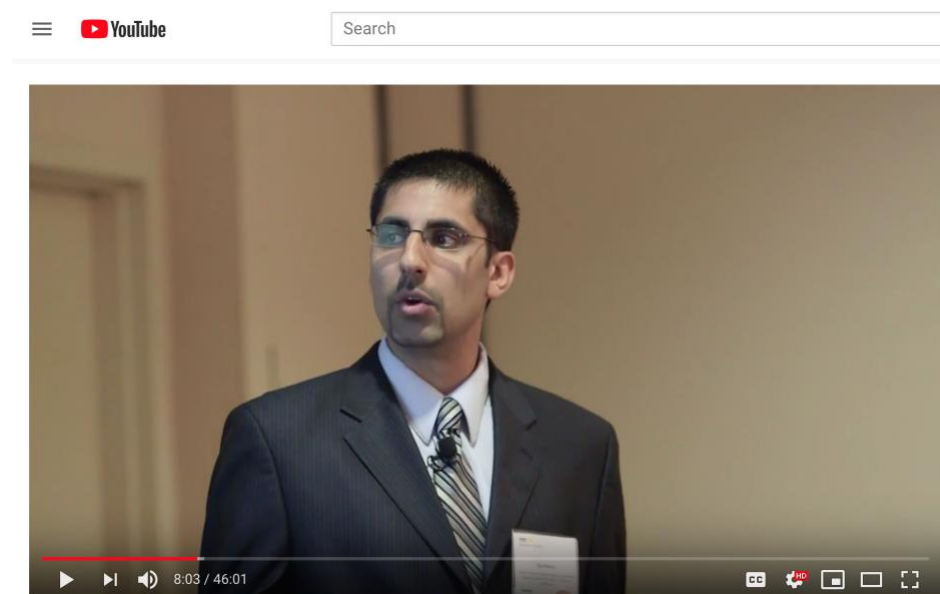
[27:53] Just as, if you go to an Airbnb or if you get into an Uber, we're able to rate those. We need to look at this idea of comparing hospitals and allowing frontline staff to have their input into comparing hospitals and everyone else as well. The NHS has started doing this. They started to do this in New South Wales as well, creating lead tables.

[28:26] At the moment they're fairly subjective lead tables. We can make them objective for each of these projects that we're trying to drive. Every equipment type out there, we can look at. We can start to rate it much in the way...I'm not sure if in the US you do this. In Australia and in the UK they have energy efficiency ratings for all of the equipment, for fridges and domestic equipment.

Mark: [29:01] Yes.

Dr. Hackett: [29:01] Yes? We can do something very similar collaboratively for all of the healthcare equipment that we interact with. How usable is this equipment? I know in the US right now, a guy that works with T. Fairbanks, Raj Ratwani is going to Congress and presenting about the issues relating to electronic health recording.

<https://www.youtube.com/watch?v=cysNJMiTgag>



[29:29] He's put out a great video presenting on that as well. They've started to grade how usable are the EHR systems, how well were they tested before they were brought to market?

[29:44] The vast majority of the equipment and the systems that we're interfacing with hasn't been tested, not only not usability tested but not even tested properly. At the very top not only is it inept but it's also corrupt. For those who haven't watched "[The Bleeding Edge](#)" yet, you've got to watch that.

Mark: [30:09] Documentary film.

Dr. Hackett: [30:10] Yes, the documentary. You can start to see how sinister things are at the very, very top. It's bad. It is really, really bad. I started to realize this again myself. Probably about three or four years ago I was called to speak to the Australian commission. They were the ones that started to reveal this to me.

[30:38] In Australia, we have the TGA which is your FDA equivalent. In the UK they have the MHRA. They're all aligned and designed based on the FDA, and work as the FDA do, and follow the FDA's lead. I was trying to introduce some other obvious changes.

[31:03] I said to the guys at the Australian commission, "You know, all of this seems to stop at the TGA." They said, "Well, we're not surprised because they're completely funded by the companies that they're supposed to govern." I glossed over what they said initially. Then I went back to look at it. I thought, "Hang on. This is a real conflict of interest here."

[31:27] If we're trying to introduce safer equipment, and safer systems, and more usable equipment, then we need independent input into this. We can't be controlled by the companies. Unfortunately, that is what's going on right now.

[31:43] To give you an example, one of the antiseptic solutions called hexetidine, there's been a series of ongoing cases of patients having it injected inadvertently, people mistaking it for local anesthetic, or saline, or other colorless solutions. It's so poorly colored. There are companies that make it very vividly colored. There are companies that make it poorly colored. There were two.

[32:14] I got in touch with them. One of them met up with me. They tried to understand what the issue was. Then they went, "Right, OK. We don't want to be involved in causing patient harm. We'll go back. Please do give us time." They spent a year. They managed to introduce a dye into their product so that we're less likely to inject it.

[32:36] They are still trying to get that product licensed, three years later, through the TGA. In the meantime, another big, big company, they turned around and said, "Look, we don't care. We're TGA-approved." It's like, "What? You don't care about this issue?" They don't.

[33:00] Unless we make them care, they won't care. Unless we start to impact on the reputation of these big companies, unless we start to stop buying from these big companies who refuse to listen to the frontline when we want to introduce patient safety solutions, they will not change.

[33:21] We need to force their hand. We can do that collaboratively. Perhaps, right now, that is my biggest threat. These people will come at me as well next. [laughs] Watch this space.

Mark: [33:37] What I hear you saying is that the response or the...if you will, resistance to the cap with name and role on it, it goes to deeper issues than that you said earlier. If I heard you right, now the people who speak out as being opposed to this simple innovation or maybe exposing themselves as the people who are status quo defenders.

[34:06] I'm curious. How much of that is just power dynamics? As an engineer, it's hard for me to completely relate. Is it just that the more senior people just view improvement as a threat to their reputation that, well...

Dr. Hackett: [34:25] That may be. Maybe there is a fear of losing some control. Maybe there is a fear of doing things in a different way. We have to overcome that fear within them. None of these

people are bad people. No one's bad. Everyone wants patient safety to improve. We just need to understand how we've been so heavily conditioned in these environments.

[34:54] Even this one individual who, in my own institution, has threatened legal action against me, he's not a bad person. He's highly, highly dedicated to healthcare. He's highly, highly dedicated to looking after patients. He's an amazing person.

[35:17] I see it is hardest for him to accept it more than anyone else. He may never. He may die and never accept it. If he is able to accept it, then my respect to him is greater than to anyone. It will be so hard.

[35:45] It is almost like telling someone they have to change religion. It's that culturally ingrained. This is what we're up against. We are very, very strong cultural animals. We're very, very strong social thinkers. To agitate against that, you really do expose yourself to a lot of threats and intimidation that will come your way. It is difficult.

[36:21] Quickly, before I forget, just going back to the equipment issue. In the UK, they have a company called Which. In Australia, they have a company called Choice and they assess domestic equipment. I was fortunate enough to go and meet up with "Choice" magazine and go into their factories where they assess, independently, all the equipment that is used. Really, really nice. CEO walking around.

[36:55] Everyone was really good, positive frame of mind. They were asking me why I was there. At the conclusion of our meeting, the CEO said, "Look, I think you, you're where we were back in 1953." That really hit me. I thought we were back in the '70s, but this just dawned on me, we're way back in 1953, but in a much worse situation.

[37:24] There is no independent assessment of the equipment and systems. We need to bring it in. Unfortunately, we working now on the front lines in some of the most complex environments, which we really struggle to simplify.

[37:43] Another example that I'll touch on, because it's so ridiculously simple, I don't know if I've mentioned it to you, Mark, but I'll bring it up again, is the arrest alarm. I've started timing how long it takes staff in theatre to find the arrest alarms. Every minute that goes by, the chances of a patient being shocked out of a shockable rhythm decreases by 10 percent every minute, so adjusting trying to find the arrest alarm.

[38:16] One of one of the staff members took two and a half minutes. This is just one room. Took two and a half minutes and then had to give up. They just couldn't find the arrest alarm. There were so many other objects, which is light styles on the wall that look like they could be an arrest alarm. It could end up being hidden behind a paper sheet, a path slide.



[38:43] This amazingly simple design at Monash Hospital down in Melbourne, is just to draw a red stripe from the ceiling down, like a big thick red stripe of paint down to where the arrest alarm is. It's brilliant in its simplicity, but healthcare, it will take us years to bring something like that in right now. This is how bad healthcare is and how resistant it is to these things. We need to change.

Mark: [39:22] You said the hospital where you're going to today, everyone's wearing the caps. There's one other, one of your hospitals I read from one of your other interviews, one of the hospitals where you've been barred from even talking about it. Can you share some of the details in that specific case?

Dr. Hackett: [39:40] Yeah. It's before the initiative even had a hashtag ([#TheatreCapChallenge](#)), which the hashtag was started by a student midwife at the time, Alison Brindle, who is based in the UK.

<https://twitter.com/BetsyLehmanCtr/status/959163226935218178>

[39:55] Only about six months before that, I'd been walking around for a while with my name and role on my hat. I'd send emails to senior representatives of the theatre, and say, "Look, can we trial this, at least, you know, give it a go? We don't have to force it on anyone but let's just give it a go and see."

[40:16] Didn't hear anything back for months, kept emailing. Eventually was told, "Yeah, we've just knocked it back." I carried on doing it. There was a nurse in my theatres who also, within her own theatre, she got other staff to put their name and role on the hat with a bit of sticky tape.

[40:41] The senior nurse came down and insisted that they take them off and told them that they looked unprofessional. I got this senior nurse. When I heard about this, I got her to come into my anesthetic bay, and look through the window in the theatre that I was working at.

[41:00] I said, "Look, have a look at the people in there. Can you tell me their names?" She could name two out of the seven. I said, "Look, welcome to my world. This, this is the world that I'm working in, and you're stopping us from introducing something that would make that better," and then just walked away. You can't you can't really combat that too much.

[41:28] Then, what happened, we were putting pictures out on social media. My brother-in-law is the creative director in advertising. I'd been telling him about this initiative for a while, but then Alison Brindle put the hashtag out, [#theatreCapChallenge](#), and she put a picture up. I just thought, "That is absolutely brilliant. That is so good."

[41:52] It reminded me of the ice bucket challenge that went around in America. I rang my brother-in-law, the creative director, straightaway. I said, "Look. Look at this. It's just happened. This is, this will go off now. Watch this."

[42:07] Literally, three days later, it was in "The Times" newspaper in the UK. Two days after that, in "The Sydney Morning Herald." It's built and built and built and built and built from there. It's a bit of a slow burn, but yeah, it's great.

[42:26] When it was in The Times newspaper and in the Sydney Morning Herald, I then got in touch with the senior representatives at this hospital again, "Look, it's just been in the newspapers now. Can we try it now?" Again, "We'll discuss it at a meeting." It's been knocked back, again.

[42:47] This is unfortunate, so constantly tried to introduce it and pushed in a gentle manner. I've actually received funding several times from different companies, and thanks to the companies that have given sponsorship and bought caps anyway for staff in these hospitals. They've been allowing that no one stopped them from wearing them, which is good. They've been allowed to wear them and they want to wear them.

[43:20] Still, there's a lot of...I'd say, within that hospital, probably two or three percent of people are wearing name role caps within the theatre complex. I feel the biggest fear comes from staff knowing that it's not supported from above, and seeing it as a threat to their own careers if they do this thing, which is obviously better for patient care.

[43:49] We're torn. This is a moral injury that is created from that we're slaves to at least three masters. One is our career, and our family, and our jobs. Another one is to our employees, and to what our employees want. Another one is to doing what's best for our patients. When these things don't align, then it causes moral injury.

[44:25] What you're seeing here is people, instead of doing what's best for patient care, they're doing what's best for what their employees tell them and what's best for them maintaining their careers because of what their employees tell them. It's really difficult.

[44:41] I've carried on pushing. It's led to eventually me being threatened with legal action recently. Luckily, I do find myself in a very unique position in that there has been this exposure. It becomes very hard now to threaten me or push me out of a hospital because of the exposure that it will generate.

[45:14] What not to do and what I don't ever want to do is to butt heads with these people. As I said, everyone wants the best for patient care. We just have different ways that we've been conditioned. The way forward comes through understanding the motivations behind their thinking.

[45:47] Gradually, if there are these people who are insistent that they will not change and do not change, then the best option, then, is to gradually take the influence away from them. Another great book that I've read recently is [Our Iceberg is Melting](#). I'm not sure if you've come across that one.

Mark: [46:09] Is that a Ken Blanchard book?

Dr. Hackett: [46:11] I can't remember the author off the top of my head.

Mark: [46:15] There's a series of these little business fables. That's a John Kotter book.

Dr. Hackett: [46:22] Yeah, it's a John Kotter. John Kotter, that's the name. We're all bad with names.

[46:26] [laughter]

Dr. Hackett: [46:28] This is reality. From this working group, we've basically got this data that after first introduction, humans only remember 30 percent of names when we're not distracted, then we readily forget them. We are very, very bad across the board at remembering names.

[46:47] The other thing that comes into it is that we become too embarrassed to ask again. We see it as almost an affront to others to say, "Oh, yeah, I forgot your name," so we don't ask them.

[46:59] Also, the other thing that's embarrassing is for people to come up to us and tell us what their name is if we've met them before, because it also suggests to the person that they haven't got a good memory and so, "Hey, my name is this. I know your memory's not very good. Here's my name." There is this cultural aspect of why we just don't carry on sharing our name after we've met other people before.

[47:28] Yeah, John Kotter. Great book. It really is this iceberg is melting concept, healthcare, unfortunately, adversity from medical error. Everyone sort of pooh-poohs some of the data out there, medical error being handed as the third greatest cause of death, and then it causes a ruckus and people going, "No, it's not. It's the real problem with the data, blah-blah-blah."

[48:00] What is very apparent is that adversity from medical error only appears to be increasing. It makes complete sense to me that in this system of healthcare that we have, that would completely be the case. If every day we have a new piece of equipment or a new system introduced, and we have a constantly renewing workforce, then the environment just gradually becomes more and more complex.

[48:30] The more complex, the more likely we are to make mistakes. Unfortunately, at the moment, our response to these mistakes is to write another policy, send out another alert, create another education framework. That, in itself, then just introduces even more complexity into the system. We just keep making more and more of the same mistakes.

[48:57] Unfortunately, going back to my first initial driver in this, the central line, the air that had got in through the central line. Another thing that spurred me four years ago, I was given the raw data on the central line air embolism deaths from New South Wales, the state that I'm in. We'd had something like 51 cases with 6 deaths over a span of a year.

[49:32] They were just the reports. All of these cases completely avoidable. I was approached by the Clinical Excellence Commission in New South Wales. They said, "Look, do you have any suggestions on how we can help fix this issue?"

[49:51] As I looked at the raw data, I could see how every single one of those cases happened, and made a lot of sense to me. I sat down with them and said, "Look, do you have anyone who works as they would in the aviation industry who investigates this stuff?" They said, "Oh, yeah, we've just employed a human factors expert in healthcare. He's a first in Australia, a guy called Thomas Loveday."

[50:19] He was the first human factors (we call it ergonomics) expert, to be employed in healthcare in Australia. He left six, nine months ago. We have no ergonomics experts at all in healthcare in Australia. I think there's probably one or two in the whole of the NHS at this stage, and maybe a smattering in the US.

[50:48] What we do have is a lot of people who think they know what human factors is, but they probably don't understand it. There's nowhere to be trained in it. Their understanding is certainly nowhere near this guy.

[51:01] I met up with this chap, Thomas Loveday. Lovely guy. I said, "Look, I think I've got a bit of an idea how we can fix this problem. I've brought together a lot of the forms that we have into a single form just focusing on the saving issues." I handed it to him.

[51:24] He said, "Right, yeah, it's really good. What you want to do is take that to the nurses on the wards who are going to be interacting with it, and get them to tell you how it will fail."

[51:34] That's when it hit me. It was like, "Oh, wow, these people think completely differently to us. What is it? What do they know that we that we don't know?" There's a lot that they know that we don't know. That's what I've been learning about over the last few years.

[51:54] With the Clinical Excellence Commission, eventually they put out a Clinical Focus Report. In fact, I presented this within one of my presentations just two weeks ago to the registrars and said, "Look, you know, who's seen this Clinical Focus Report?" It was a room of 30 people, 30 anesthetists within New South Wales. None of them had. I don't expect that any of them will have done this.

[52:23] This was the PS, the resistance. This was how the Clinical Excellence Commission was going to stop this issue. No one's even seen it. There is so much information out there. Writing another policy or writing another document isn't going to have any impact on the frontline.

[52:41] I subsequently met up with the people from the Commission and said, "It's great document. You do realize it will have no impact." They got a bit upset when I told them that. Six months later, I bumped into a few of the people from that group at the train station. I said, "Look, how many more deaths have you had over the last six months?"

[53:04] They couldn't actually say it. The lady on the on the platform just held up a hand and said five. They'd had another five deaths within that six-month period after releasing the PS, the resistance of how it would stop the problem. No criticism to them. These are great people.

[53:24] The other issue we have in healthcare is that healthcare governance, or healthcare governance as individuals, they have a very finite lifespan. They move from one job to the next. Within the first year, 30 percent will have moved to another role. Their average lifespan is three years. There is no organizational, or very little organizational memory in healthcare governance.

[53:57] All of the people that were involved in releasing that document have now moved on. They're not involved in that project. I've continued it on through the [Patient Safe Network](#). One thing that we did put out was a video, an animation video, a short one. It just highlights the issue. Within that video, it says at least one person dies every day from this issue.

[54:34] From my reading and from the data that I've collected, I think it's actually worse. I think today, somewhere between three and seven people will die from a central line embolus across the world. Every single one of those cases will be avoidable.

[54:55] The simple interventions that we would be able to put in place to stop this, we still haven't put them in place. One of the presentations that I give talks about this.

[55:10] The second presentation uses one of the simple interventions and the resistance to it to explain resistance within the industry that we're seeing with the caps as well.

[55:24] It's really sad. It's really really, really sad that I work in an industry where I know people are dying because of our errors. At the moment, we seem incapable of changing that. There is a way forward. I can see what it is. It occupies pretty much all of my thinking space at the moment. We will get it.

Mark: [55:55] There's a long history of changes taking 19 or 20 years to be adopted in healthcare, even things that seem so obvious in hindsight. There's a lot of things that are discouraging. I feel the same way.

[56:13] One thing that's very encouraging is just scrolling through Twitter and the #theatrechallenge and seeing the smiling faces of people with their name and role on their hat. There's one I'm scrolling through. It actually says Deborah Lee, Chief Executive. Good for her leading by example.

Dr. Hackett: [56:33] That is great. Deborah Lee, I never met her, but she's a CEO. By the looks of things across the hospitals, they just bought caps for all of their staff within theatre.

[56:48] Another comment that came from that tweet was from an anesthetist down in Melbourne who's like, "Wow. CEO in theatre. I've never even seen my CEO." This is the reality of it.

[57:06] 25 years in healthcare, I have yet to have any manager at any level come to me and say, "What is it that we can do to make your workplace better?" That needs to change. That needs to change. It's obviously changed in that hospital. They have a great culture.

[57:28] I want people to see that. I want patients to see that. I want them to know that you go to Gloucester Hospital, they have a progressive culture, and you are going to get much better care than anywhere else. This is how we work. We start impacting on the reputation of institutions. If they're not doing these things, people will be able to see it and your reputation is at stake here.

Mark: [57:58] Lives are at stake.

Dr. Hackett: [58:00] Yeah, lives are at stake, reputations of institutions are at stake. This is how we will have to work... for now. Until it becomes accepted part of healthcare, we will have to push quite aggressively and impact on hospitals' reputation to implement ergonomics.

Mark: [58:22] I appreciate that you're pushing. I know, the world is pushing back on you a lot of ways. Just trying to scroll through pictures of smiling faces with hats, I see the people pushing back.

Dr. Hackett: [58:38] Yeah, the trolls are out there. This is what it's about. It's about exposing that negativity that exists out there. I've got a thick skin. I can understand why these people are the way that they are. I get that they're good people as well.

Mark: [59:02] They're good people but they're stuck. Hopefully, we can help them. There's somebody pushing back like, "Where's the evidence that proves this is a good idea?" Well, where was the evidence that said not having the name on the caps was a good idea?

Dr. Hackett: [59:20] The reality is we have a ton of evidence. I push it onto these people, but they'll still say, "Oh, we need more. We need more. We need more." I could exhaust them with evidence

it's so obviously better. I have no fear that running simulation studies will not show that this is better for patient care. It's so ridiculously obvious.

[59:45] It just exposes we've been ingrained in an evidence-based, a conditioned practice, which I'm completely supportive of evidence-based medicine when it's used appropriately. Evidence-based medicine was never designed to disprove basic science. This is what these people are trying to do. It's being there, used as an obstacle to change.

[1:00:11] Whilst I talk about things often in a negative way, there is a lot of good. Thank God for social media, or thank goodness for social media, because I've been able to meet so many, many, many, many passionate people around the world who are...They're as passionate, if not more passionate, than me at driving this.

[1:00:38] Being able to connect with them and help drive this further and further is just brilliant. It will change. If we didn't have the Internet, then we wouldn't be able to change healthcare in the way that we're about to. Massive kudos to everyone out there that's pushing for improved patient care because it will come, and it will come into the industry.

[1:01:13] My hat goes off to everyone. My hat goes off to everyone who's helping push forward -- the patients, managers, the manufacturers that are coming on board, other healthcare staff. It's great to see it start to move.

Mark: [1:01:32] I want to really thank you, Rob, for being here today and sharing what you've been doing, what you've been facing, what you continue to fight for. I appreciate that. I know you have to get off to the surgical theatre. I don't want to hold you back from that. I encourage people, go visit the Patient Safe Network at psnetwork.org.

[1:01:58] Rob, as a final thought, can you share a little bit about that organization?

Dr. Hackett: [1:02:03] Yeah. Basically, it's a network. Anyone can be involved. What we're pushing back out and driving are just great ideas and great change and great improvements. There's tons. It just comes. People send it to me, and we generate collaborative groups that focus particularly on that project, and then we just push it out and try and drive it everywhere.

[1:02:38] All of these projects will have international resonance. Sometimes, all it takes is just a couple of completely passionate people. They can drive things really farther.

[1:02:49] There's a big change just about to happen in emergency departments and elsewhere. We're looking at something called an anti-oxygen monitoring. The data that we've got from this working group, pretty much driven by two passionate individuals, Dr. Matt Oliver who's in Sydney, and Dr. Nick Caputo, who's in New York.

[1:03:15] These guys have never met each other but yet we've been driving this project for over three years. It's so fascinating seeing this go. What we've shown is at least less than 25 percent, probably less than 10 percent of patients outside theatre right now across the world are pre-oxygenated, given sufficient oxygen before they're put off to sleep and have a breathing tube in.

[1:03:46] Just by allowing people to see the anti-oxygen, we're able to flip their...Completely the other way, and then 90 percent of people. It's just about being pre-oxygenated properly.

[1:03:58] All it takes is a few passionate people. What the network gives are great tools for those projects to be driven networks through connections through other people throughout the world -- connecting with advertisers, connecting with the manufacturers, connecting with everyone.

[1:04:24] Transparently keeping it out there and saying, "Look, this is where we're up to." Who knows where the next or where the amazing ideas are coming from?

[1:04:33] They can come from people who are not on the frontline, you know, anywhere. We're able to tap into that. It's just great seeing it grow. Mark, I really appreciate the plug. That's very, very kind of you. Yeah and look, really appreciate what you're doing, as well, in the industry. Stick with it. It will get better and better.

Mark: [1:05:00] I hope so. [laughs] Thank you for those words. Thank you for joining us here today. For the people listening, go to the blog post for this episode. There'll be all sorts of links and more that you can check out about our guest, Dr. Rob Hackett, and the others who are involved in this really important movement. Not just around the theatre cap, but around patient safety and improving health care.

[1:05:25] Rob, thank you so much. I hope you have a great day. Thank you for being up so early in Sydney.

Dr. Hackett: [1:05:30] No worries, Mark. My pleasure, mate. All the best.

Mark: [1:05:33] You, too. Thanks.

Dr. Hackett: [1:05:35] OK. Bye.



Questions, Topics, and Links:

- PSNetwork.org
- [Where's the Evidence?](#)
- Rob on [Twitter](#) and [LinkedIn](#)
- The Patient Safe Network [YouTube Channel](#)

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