Beyond Training: Simulation as a Healthcare Asset with Dr. Rebecca Szabo (Episode 89) Transcript

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Introduction and Conference Background

I am overjoyed today to have Dr. Rebecca Szabo with me. She is a simulation educator from Australia. She'll tell you more about her bio in a minute. The best part of having this podcast is getting to meet with people that blow you away.

And we'll get into it in a little bit. She has this very insightful paper that has really put into words pretty much all the pain points that I'm experiencing right now as a simulation director.

So Dr. Sabo, it's wonderful to have you on the podcast. It's very nice to be here. Thank you so much. I'm absolutely blushing on this side of the globe with that introduction and I'm really excited to stay with you.

It has been such a joy getting to know more people from Australia. And we were just talking before we started recording that a lot of Australian simulation leaders go to another conference.

Can you tell us about the conference that you say is the one you don't miss every year? Well, I've just come back from SESAM, which is the European Simulation and Healthcare Conference, which was in Prague this year and will be in Valencia in June, 2025. So I don't know if this is going to land with a North American audience, but there's a song contest called Eurovision.

which is very popular in Australia. I watched it as religiously with my grandmother and mother and sister growing up. And so we've always joked that Australia is like an extra part of Europe because actually Australia have a spot in Eurovision or have had like a nominal spot for the past, I think it's five years, it might be longer.

And so we just joked that there's a very big Australian contingent that go to CefSAM because it's a bit like Eurovision where like an honorary part of the European society, even though we're all the way on this, in this part of the world.

I love that. I'm even more excited to go now that I heard it's in Spain. That's one of the countries I haven't visited. So we're going to make it happen.

So the way we like to start off the pod is share with us your doctor origin story. Why did you go into medicine? So when I heard you were going to ask me this, I've never heard a phrase like that before, doctor origin story.

I quite love that. And I'm going to use that. I'm the first medical person in my family. And I was actually born at 28 weeks. So I'm an ex-Prem baby. And as a result spent a fair amount of my childhood in and out as a scene specialist.

And with a few medical problems, not too bad for an ex 28 week Prem who's my age. And really medicine was not on my radar as a career, even though I had been a patient quite a bit.

But I spent some time really loving science and those sorts of things. And actually my science chemistry teacher in high school said, have you thought about medicine?

Dr. Szabo's Doctor Origin Story

And I think if it hadn't been for him asking that question, I would not have been something I had considered, even though I had been on the other side for as much as I had.

And so once he said that, it just made complete sense to me because I had really loved science, even though I was someone who always did a mix of humanities and sciences.

And so that was kind of how I ended up going into medicine and medical school. In part, because of that kind of origin story of having been in exprem, I would not have chosen to do.

I'm an obstetrics and gynaecologist prior to doing medical education and simulation. And actually I probably would have paid money to avoid that reservation in medical school if I quit it.

But did that rotation and ended up having a great affinity for us and made a lot of sense. And so that's really the short version of how I ended up doing obstetrics and gynecology.

The reason I ask the question in that way is superheroes, their origin story is always like the back story. And I know we both have a qualitative research background and you learn over time the way you choose words.

evokes different responses. And so Origin often gets people to answer a question exactly how you did, digging deeper into, why did you go into health care?

Sometimes you get a very superficial answer. So I love that. And the reason I ask this question is almost everybody I have on the reason they got into health care is not the same reason they're in health care.

It would be cool someday if I do find a guest that it's the same. But my prediction is I won't. So what keeps you in healthcare right now? Interestingly, I actually think for me, it does tie back to that origin story.

So, and I have spent quite a bit of time thinking about this, I think particularly in light of the past four years with pandemic and those sorts of things and thinking about our values and why we do what we do and why we continue to do what we do.

And a lot of what I do with in-simulation and using simulation for quality improvement and patient safety. And I think particularly because I am an obstetrician gynaecologist and I work in, so I work at the Royal Women's Hospital, Linnikley.

And also most of my scene is there, which is a standalone hospital providing maternity, newborn care and gynaecology services. And so a lot of what I do is still around maternity newborn emergencies and.

making things better, both for our healthcare teams and also for our patients. And so I think a really big part of why I went into healthcare was to help people and a little bit to understand the experience that I had as a patient and to ensure that the voice on the other end was heard.

And also there's some other background in terms of my mother's obstetric history, both in my pregnancy and then later pregnancies. So I think. I think I'm still here for the same reason.

It might look a little bit different, but I think the reason is the same. That's really beautiful. When you decided to become a doctor early on in medical school, did you have any idea that you would gravitate and have a large part of your career be simulation education, or where did that start to enter the story?

No, I did not know that, although I was involved in, peripherally I was involved in medical education and education very early on. I was one of those people who was secretary of our student society and in being a representative on that, you ended up being the student representative on meetings with the dean and others to ensure that there was a student advice in terms of curriculum and other developments.

So I think I've always gravitated more to that and have been involved in tutoring or education in some capacity from medical school. In terms of simulation based education in Australia, it started around the time that I was towards the end of medical school.

And so I was one of the first students in Australia that was really part of a dedicated simulation program. And I feel very privileged for that. I guess was really energized by it, but I don't know that I ever envisaged that I was going to be on the other side providing it, other than I loved it.

So I think going back, it kind of makes sense in that regard. So the point that I really got involved in simulation is also an interesting origin story or part of the story in that I did three years of gynecological oncology.

So I actually stepped away from obstetrics entirely. And I just did gynecology for three years. And then I changed my mind and I was like, I'm going to go back and do general obstetrics and gynecology.

And in doing that, because I had not looked after any pregnant person for three years, unless they had a cancer. I did a simulation workshop called also, which is the advanced life support in obstetrics course, which is a two day simulation based education, maternity and newborn emergency cost.

So I did that and then I went back and I clinically worked in obstetrics as well.

How Simulation Entered Her Career

And they actually invited me to become an instructor. And so it was from that experience of becoming an instructor and doing more in that space that I had been doing a little bit of tutoring and education in gynaecology and surgical education and that type of thing.

But I got much more involved in team-based emergencies and more immersed in simulation-based education and then did a graduate certificate in teaching and then went on and did my master's in clinical education and in some research work in simulation.

And then from there, developed the business case for the simulation program I now lead, which is Gandalf Simulation Service. Wow, that is such a cool story.

And I think it's really important that we share these stories because simulation isn't a super common path. I think medical students and residents have, if you want to do a fellowship in something or residency, that path is more clear, where a lot of us as simulationists still wear a clinical hat.

And so I think getting these stories out about what brought it into our careers. And at this point, I tell people simulation is what's keeping me in healthcare.

It's not my clinical work. It's my simulation work. And right now I still think doing clinical work helps my simulation work. Yeah. I think the other part of the story and the conversations I have particularly with peers and people who are senior, but primarily with people who are junior, is it's not a straight line.

I think that there is a risk and I think I had this vision as well that it's a bit of a straight line or a treadmill or a conveyor belt and you go from here to here.

And if you don't do that, then. Either that's a failure or that's a problem. And actually the beauty, I think, particularly in medicine, where we're really fortunate and it's in general truth across healthcare is that we might start as a clinician or in one spot and we have the opportunity to move around and do other things in the most part.

Not everybody has that opportunity. It's a privilege that I've been able to make the decisions I have and try different things. and do different things.

And I think you're right, like I think simulat- my answer is probably the same is that simulation keeps me in healthcare, but I also still have a clinical role and it's the way the two intersect that keeps me happy.

Because I think if I just did one and not the other, I contribute as much in each. But it also just wouldn't give me the joy that I get out of combining the two.

And that will probably change, um, because there's also, I think, a little bit of attention and really hard to stay on top of things in each area. That's the challenge of doing a few different things.

But I think the beauty of having your cup filled from a couple of different areas is something that I feel really lucky to have. Absolutely. Well, I want to dig in to this wonderful paper that you published called Leaders' Experiences of Embedding a Simulation-Based Education Program in a Teaching Hospital and Interview Study Informed by Normalization Process Theory, which was in advances in simulation in this year.

And there's an infographic that's brilliant. Please, Rebecca, school me on this paper. I mean, thank you. And I really want to acknowledge my co-authors, but most importantly, the participants who contributed to this work.

And I think to go back to your origin story, the reason that this paper exists is because in creating the business case for for funding and to establish scandal simulation service and then embedded and keep them going.

Lots of people said to me, how is it that you got this far? And then how are we going to keep going? And the research question really came from that and the research workers is to try and share that with other people.

And so to come back to the conversation we were having about origin story and qualitative work, it's really well.

The Research Paper on Embedding Simulation Programs

I was having this problem six years ago when I was wanting to establish a simulation program in a hospital that was established in 1865, but didn't have a simulation program.

And so I know from conversations with many people and including lots of people having this problem with simulation, and we've found this in this study, but anecdotally prior to that, simulation is not normal across healthcare, despite that it has existed and we have evidence thousands of studies that show it works as an education tool and increasingly as a quality improvement tool, it isn't normal.

Like it's still something that struggles to get funding and get buy-in. So that's the origin story of the paper and the research and why I'm doing a PhD.

And so, as you said, there's, there were four themes that were generated from speaking with leaders in simulation across Australia, Canada, and the US.

And that was a really interesting thing as well for me, that whilst things were context specific, the challenges and enablers were really the same across each of those countries, which have relatively different healthcare systems, particularly in the US to Australia and Canada.

Because we have an universal health care, or whilst we have a kind of two tiered public and private in Australia, pretty much we have an universal health coverage.

And so those four themes are leadership, a business startup mindset, tension of competing objectives, which is really that challenge of how do you provide simulation, but also In many instances, it's put on the simulation program to make money and to generate their own income rather than have an operational income a bit like an emergency department or operating suites or that type of thing.

And the really key one which you and I have touched on off the podcast is that there's a poor understanding of simulation which undermines normalisation.

And that that poor understanding isn't just with executives or managers or outside of healthcare, it's also within healthcare and sometimes even with healthcare educators and sometimes even with people who do deliver simulation based education because there's a poor understanding of the breadth of what simulation can deliver.

So let's start there. Let's say you have a new executive, new to the C-suite. They've seen the line item of your

budget and they ask for a meeting and say, Rebecca, What is this?

You're spending a lot of money. You've got an executive, maybe they have an MBA. How would you explain what simulation is? So I'm going to flip the question.

I think it's really important to understand the person we're speaking with. But I think a lot of the time as medical educators or healthcare, health professional educators, whoever the audience is that I'm talking to now, we know that we need to know our audience.

We teach that in education. You need to know your audience. You need to know who you're speaking with versus getting up and giving a PowerPoint presentation and you just give the content that you're interested in versus who's the audience.

that you really need to know your audience. So either if I had enough warning, I would do my homework before I went to that meeting with that executive and find out a bit more about them because I'm going to need to speak in language that is meaningful to them.

So not just about the C-suite, but like you just asked me in my origin story. So I'm Australian, I come from a non-healthcare background. I'm in obstetrics and gynecology and I did these other things.

It would be more about me in terms of having that conversation. So either I would do my research before I meet them or I would have a conversation with them to try and understand them first.

So I can then give them the right analogy because unfortunately sitting in front of them and giving them my version of what simulation is, I've found is that most people including, and the best is to actually have this conversation with lay people.

who as a general rule will, like if you start to explain to them around the classic example is the NASA example of how do you get to the moon or how do you get into space and what type of simulation happens for that or high risk industries or those sorts of things, then that seems to land quite well.

But then it depends on who's sitting in front of you, because if that person does have a quality and safety background, or that's their priority for the hospital or health service at that point in time, then using that language and those examples will be really useful.

So yeah, I think from my point of view, it's really important to know the person in front of you and what examples, what language is going to be useful for them, but also what their priorities are.

That's really helpful. So you just, you've got to do your homework every time you're telling this story. Yeah. I mean, I think you need to know, I just talked about this two weeks ago at a different conference and an Australian education, health professional education conference and said, what I wouldn't do is use the word education.

So I would remove the word education and that really bothered a couple of people in that room because it was an education conference. And so I said, right now, so we're at Adam, I think a lot of the world is in this situation in terms of a particular geopolitical thread at the moment as well as.

economic issues, but particularly in the state that I live in, I'm based in Melbourne, Victoria, Australia, and Victoria has significant debt at the moment and we're about to undergo health service reform.

And so they're asking at the moment each health service to cut their budgets. And what we know is that education is cut from budgets first. because, partly because there will be some administrative things that go, but education is one of those things that is really not necessarily seen as essential, particularly when they're trying to save clinical services.

And so if we frame simulation, and this is what we've said in the paper, if we frame simulation as a patient safety

mindset, this is about making things safer for patients and providing best care.

And for the C-suite, they might be more concerned about efficiency. And we've talked about how do you demonstrate value and return on investment and what does that mean?

And that's why you need to know what their priorities are and really land with that. And so I think not framing it as education. However, if that person, if I was sitting in front of them and actually education is really important to them, then I would be leaning into the word education.

It is around still being able to explain that simulation is about recreating reality without harm to patients. But that can be used both for education, for team training, for testing systems, for testing equipment, for creating.

a building or creating, doing prior to renovation so that we're sure that our staff are working to the best of their ability and efficiently in a space that will also be the safest way to provide care, which would save money.

Explaining Simulation to Executives

Cause if we can work that out to start with and then we're going to reduce the workarounds and errors. The answers to that question is it depends on the person in front of me and knowing what their priorities are.

So I would be asking them what their priorities are. and trying to understand who they are. Yeah, always sage advice to seek to understand before going in.

I've been thinking a lot about this tension between revenue generation, doing something for an outside entity at your sim center versus the cost savings potentially.

internally. And one thing I've been kind of sharing with the group I work with is I really think we are sitting on I guess, a gold mine to save the hospital money.

And I want us to use that and maximize it for our own internal benefit before we would open it to outside people. It seems short-sighted to me to not maximize and almost like an ethical imperative to me that if there's things around here that simulation can help make better for patient safety quality.

And then increasingly for me is the healthcare worker wellbeing because we do know a lot of literature that when something goes wrong, obviously it's terrible for the patient.

It's also terrible for the healthcare professionals involved and they do leave medicine frequently or nursing after something happens. And many of them switch.

If it happened in the emergency apartment, they'll switch into something else. And my question for people is, I get asked all the time, how much does SIM cost?

I'm like, well, what's the cost of not doing it? And it's one of those nebulous questions. But what are some of your reactions or some of the way you frame these type of conversations with people?

I'm nodding furiously to everything you're saying. And I think that this is a really important area that we need to explore and understand. Lisa Barker, who is a jump simulation, is really leading the way with this looking at values based simulation.

and others, including Katie Walker. So I think that's really had an interesting conversation recently with someone around the difference between return on investment and value.

How do we measure or also place value? And you just described that people often ask, what is the cost of simulation? Do they ask what the cost of providing care in an emergency department is or what is the cost of providing care in an operating suites?

You know, and in the US, yes. And in Australia up until recently, no, but we're starting to have those conversations. But you know, how do we measure the value of a clinician?

Do we do that? Again, to be curious and ask the question, why simulation in a space where we're constantly kind of trying to justify our existence, both through cost and just being there?

And I think that kind of hit the nail on the head a little bit. If we can reframe the conversation of, well, by not having simulation, what is the cost of that and what is the value add and how do we demonstrate that?

value to an organization so that they are seeing that and that realistically them having that operational budget for simulation. Okay, well, we're doing that because we're saving here and we're adding value here and here.

As I said before, there are thousands of studies on, when I joke that there's the study that demonstrates that the program for simulation for the little finger, We have those studies, that's great, but we need to increase our understanding of how we can demonstrate value.

And that might look, as I said, like we need to understand who we're speaking to in the C-suite. So for each organization that may look different, but we really need to demonstrate, I think, value-based simulation and what we add, because what happens if we're not there?

Yeah. I'm curious what the state is in Australia compared to the United States around regulatory requirements for simulation. I'll use the US as an example.

I believe, and I'd love it if a listener can correct me. send me a message if I've got this wrong, that in the United States, the only simulation requirement by J. Co.

is actually around maternal medicine, that the hospital is required to have some obstetrical simulation. Now, what's interesting is what you find out when you walk around and you ask people, oh, I hear you have an obstetrical sim.

What is that? The answers you get really are coming down to tabletop. There's great literature on lo-fi, sim. I'm a huge fan of you don't need to have all the bells and whistles.

It's much more about the educational environment and the, I mean, speaking to the choir here about goals and objectives, all that kind of stuff. But I'm curious in Australia, has there been any regulatory requirements for simulation?

So the answer to that question is we're a federation of states because we're a Commonwealth. And so the regulation is at this stage, well at this stage there's no regulation, but there is an incentivising program in Victoria.

Value, ROI, and Regulatory Incentives

So to my knowledge, there is no incentivising program anywhere else in Australia at the moment. Victoria is the only one. And interestingly, at the moment, the incentivising program is only for maternity.

And so it's one of the reasons why Gandalf Simulation Service exists. And one of our biggest KPIs is to meet this incentive program, because the way the incentive program works is that if we provide a certain amount of maternity emergency team-based simulation, as well as some newborn emergency simulation and there's, cause it's a whole bundle, some other education within that.

To 80% at least of the staff that work on our birth suite. Then the hospital gets back 5% of its insurance premium. And that fight, the agreement with the hospital is that five percent goes, that a hundred percent of that five percent goes back into game or simulation service.

And that's an annual reimbursement. So it's an incentive rather than a regulation. in terms of the place in the world that I know that has the most mandated regulation is Norway.

So the government of Norway have mandated simulation in every hospital in Norway. And we often hold Scandinavia up as an exemplar. So Norway is really that gold standard.

Interestingly, there's the mandate because it's within law, but no funding to support that. Oh, our favourite, an unfunded mandate. That's just the best, isn't it?

Whereas, so I think the mandate and the stick is a powerful thing for the healthcare institutions to have to work towards and really significant that has come from a federal government and national government level.

But there are then challenges in how do you do that? But it's mandated. So, and within Victoria, we've got the opposite. Like it's regulated, but it's incentivized and therefore, and there's funding with it.

So that program is likely to move into also the perioperative area. So there's a pilot program at the moment to look into extending that to support perioperative team simulation.

And I'm actually involved on a steering committee to kind of… support and evaluate the pilot. And, and that's partly because the maternity program has been so successful.

And my understanding in the US is that there is a similar program for the Harvard group of hospitals. That there's like some sort of incentives that comes back from the insurer if simulation is met.

So I think regulation around it is relatively thin on the ground from a government level. And the other paper that's recently been published in Advances in Simulation, which is the Global Consensus Statement, has really given a call to action to start to have these conversations with regulatory bodies and governments and others, recognizing that if we can have mandates and those sorts of things, perhaps that will help.

in relation to that, talking about Norway, I would just urge some caution in when something is mandated, then ideally it also needs a funding stream. And also sometimes when things are mandated, they become a little bit tick the box rather than actually facilitating what is needed.

So I think there needs to be some caution around things being mandated so that it is as intended rather than becoming a tick the box exercise. But yeah, so that's where things are kind of sitting in Australia.

I think the other thing to have a think about is where things are either recommended or mandated within training colleges. So certainly a number of our training colleges are starting to have simulation as part of training program requirements within obstetrics and gynaecology, surgery, anesthesia for example, and emergency medicine are the ones that come to mind.

Yep. You absolutely read my mind that from the U S it's the ACGME. So I've been brushing up on what is actually required by each program. And I have to say, I was actually shocked looking at the lack of simulation.

in so many of the program requirements. And I just had a session with a new group of transitional interns yesterday. And the last group that had gone through, we did a needs assessment with them and asked them what they wanted to do in simulation.

And I put that up on the board. And I said, this is your simulation program this year. If we need to make some adjustments to this, let's do it. Let's talk about it right now.

They very overwhelmingly said, we want help with difficult conversations. There were two people that were already on IM wards, and we've had to be asking goals of care, and we can remember, we can relate to all of this.

And it just, again, it was, I know this, but then to see their faces and they're scared and nervous and they're wanting to do such a good job. And I'm like, oh my gosh, maybe I should have done that today instead of what we did central lines.

But yes, this is such an exciting conversation. And there's a list of questions we didn't get to. I wanted to pick your brain about VR and AR and how that's all going to fit into this.

But I'm conscious that time is running short.

Future of Simulation and Closing Thoughts

What are you excited about in the rest of 2024? I think I alluded to before, I'm doing a PhD to try and kind of answer this question of how do we normalize or embed, integrate and sustain simulation for quality improvement and patient safety in healthcare through translational simulation.

And so I am going on the sabbatical from my clinical work for three months, but I'm going to be traveling to Canada to collect some data and also speaking at the simulation Canada conference.

I'm super excited to be doing that and really have a chunk of time, just like us on the research and the work visits. We said before, there's a lot of joy in combining clinical and simulation and research and all of it, but it's also will be great just to be doing one thing for three months.

Oh gosh. Yeah. You exactly like verbalize the feeling I'm having right now. that I'm just in a messy phase of life right now. These accelerations where there's so many irons in the fire and you don't know which one's going to like become the iron.

I kind of need something to become the iron right now. So yes, I'm a little bit jealous, but I am very confident that our paths will come together again, maybe in Spain.

I'm putting it out into the universe that maybe several of our listeners will be in Spain enjoying SIM in Spain. Nice alliteration there. So I think in terms of what I would say to people is.

I think within simulation, we kind of, as we move more and more into the simulation world, we have a tendency to understandably be within our tribe and we speak about simulation to each other.

And probably just as we do in whatever clinical world we're in, whether it's emergency medicine or obstetrics and lining, we kind of have our own language or our own shorthand.

And I think you and I were talking about that you sometimes are even having to explain simulation to people within healthcare or aside from the C-suite and others.

So I think we need to really not just tell each other. We need to be telling other people about simulation and whether or not that is. on podcasts, in the corridor, in the cafeteria, in the elevator or the walk to the car or at conferences and meetings and in journals.

It's just around how we are explaining and marketing, I guess, to use that kind of business startup language from my paper, like simulation so that more people do know what it is, so that it's less work for those of us.

like yourself directing simulation programs so that if it's more commonly known and understood, then it will be long-term easier for us to get by in. Yeah, this is going to be the most I'm making a prediction.

This is going to be the most important thing that needs to happen in the next 10 years of simulation. It's not going to be the next piece of technology.

It is going to be about telling the story and it's going to take quantitative and qualitative both sides, the stats and the stories of simulation have to get out beyond.

It's going to have to get out to people we're not used to talking to. We need to have conversations with politicians. We need The five P's, the payers, the patients, the providers, pharma is one of the other P's, and the policymakers.

We have to be having those conversations. So I love that. I think we came up with some really good concepts for people to chew on. I'm going to be thinking a lot about how do I start to do that push and pull.

Probably more the pull, I think, that you identified that we need to get payers to be incentivizing simulation. Thank you for a lovely chat. Yes, thank you.

We'll have you back soon.