Staying Well in a Sea of Harm

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Sponsorships or competing interests that may be relevant to content are disclosed at the end of this article.

Abstract

Physician psychological wellness is an emergent outcome resulting from dynamic interactions among complex conditions. We may enhance opportunities for physician wellness by applying principles developed to improve another emergent outcome: patient safety. The Safety I approach to patient safety focuses on “what went wrong” and considers humans a liability. Safety II is a powerful complementary approach that focuses on “what went right” and values human creativity. These contrasting perspectives are described in the context of patient safety, but the underlying principles have relevance for physician psychological wellness. We can create conditions that interfere with wellness and conditions that support wellness. We can learn from exploring and reinforcing successes and improving routine processes; together, these approaches may have a greater cumulative positive impact than just addressing problems.1

Keywords

safety, systems engineering, resilience

Received December 29, 2017; revised January 31, 2018; accepted February 20, 2018.

Physician psychological wellness is an emergent outcome resulting from dynamic interactions among complex conditions. We may enhance opportunities for physician wellness by applying principles developed to improve another emergent outcome: patient safety. The Safety I approach to patient safety focuses on “what went wrong”: it uses critical inquiry to seek failures that contribute to adverse outcomes, and it considers humans a liability. Safety II is a powerful complementary approach that focuses on “what went right”: it uses appreciative inquiry to understand processes that contribute to patient care successes, and it values human creativity. While Safety I supports restrictions and constraints, Safety II values adaptability.1 These contrasting perspectives are described in the context of patient safety, but the underlying principles have relevance for physician psychological wellness.

Safety II defines safety as an outcome in which as many events as possible go right, rather than an outcome in which as few events as possible go wrong. In some ways, this represents 2 sides of the same coin, but it is also a paradigm shift.1 The value of understanding events in which harm was averted or prevented is more profound than just the immediate good feelings that are evoked. We cannot improve health care safety by only focusing on what not to do, standardizing without appreciating when variety is appropriate, and implementing tighter and tighter constraints. There are appropriate circumstances for prohibiting, standardizing, and constraining, but there are also circumstances in which adaptation, responsiveness, flexibility, and creativity are important. We can learn from exploring and reinforcing successes2 and improving routine processes1; together, these approaches may have a greater cumulative positive impact than that of just addressing problems.1,3

As medical director of the Pennsylvania Patient Safety Authority, I review reports of clinical care events in which patients were injured. The reporting criteria in Pennsylvania are unusually and intentionally broad. Pennsylvania’s Medical Care and Reduction of Error Act of 2002 mandates that hospitals, ambulatory surgical facilities, and certain other patient care facilities report serious events and incidents in which patients experienced or could have experienced unanticipated harm.4 Note that the criteria for reporting does not require that harm was caused by error.5 Additionally, reports include events in which the patient may have been harmed but the event did not reach the patient (“near miss”) or the potential for harm was identified as an unsafe condition.5 The authority (with educational responsibilities) and the Pennsylvania Department of Health (with regulatory responsibilities) each receive specific categories of reports.4

Since reporting began in 2004, the authority has received >3 million reports. Reports are analyzed, and the results,

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with risk reduction strategies, are published in a de-identified or aggregate fashion in the quarterly Pennsylvania Patient Safety Advisory. Patient safety liaisons provide consultations, and the authority develops collaborative improvement projects, webinars, and online courses.\(^5\)

From the 5000 reports received weekly, approximately 10 (0.2\%) are “high harm” reports of patient care events that contributed to or resulted in permanent harm, a near-death episode, or death.\(^5\) The high harm events are discussed by leadership at a biweekly meeting. We appreciate the value of understanding events in which patients were harmed, and the importance of preventing similar events in the future. However, merely focusing on events that go wrong limits the lessons learned to prevent future harm. There are many more events that go right, with their own lessons to be shared.

In some event reports, a health care provider or other facility staff intervened in a way that prevented harm from affecting a patient. These reports demonstrate situational awareness, exceptional medical knowledge, or an ability to advocate for a patient in challenging circumstances. In other event reports, the patient’s outcome may or may not have been optimal, but the health care personnel involved took advantage of information learned and developed system-level interventions designed to prevent future harm. These reports are valued because the health care personnel looked beyond correcting problems for the patient at hand and addressed underlying conditions to protect future patients. We discuss the rationale for the selection of each report and the safety improvement implications, and we appreciate these true stories of health care provider knowledge, skill, diligence, and insight. We send a formal letter of recognition to the facilities that submitted the selected examples, and we have received anecdotal feedback that this acknowledgment is appreciated and even desired.

How does this process relate to physician wellness? While most health care providers are well educated, dedicated,\(^6\) and self-motivated, our letters may reinforce and validate their decisions and actions. Our modest Safety II activity is a small step with a large goal: transforming our perspective. Learning by sharing expertise is not new to surgeons. We explicitly examine and improve factors that enhance patient outcomes; we can do the same for physician wellness.

Physician wellness is an emergent outcome: we can create conditions that interfere with wellness and conditions that support wellness. Integrating appreciative feedback and recognition into existing activities is one way to start—specifically,

- During focused or ongoing professional practice evaluations, we can acknowledge and reinforce knowledge, skill, and diligence.
- During morbidity and mortality conferences, we can examine patient care achievements.
- In a more immediate manner, as we debrief our trainees or ourselves after surgical procedures, we can reinforce “what went right.”

In addition to learning from failures, there is much that we can learn from success.

**Author Contributions**

Ellen S. Deutsch, conceived and designed the work; drafted and revised the work; approved the final version; and agrees to be accountable for all aspects of the work.

**Disclosures**

Competing interests: None.

Sponsorships: Pennsylvania Patient Safety Authority (an independent state agency), manuscript review.

Funding source: None.

**References**