Why Safety-II Matters

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Outline

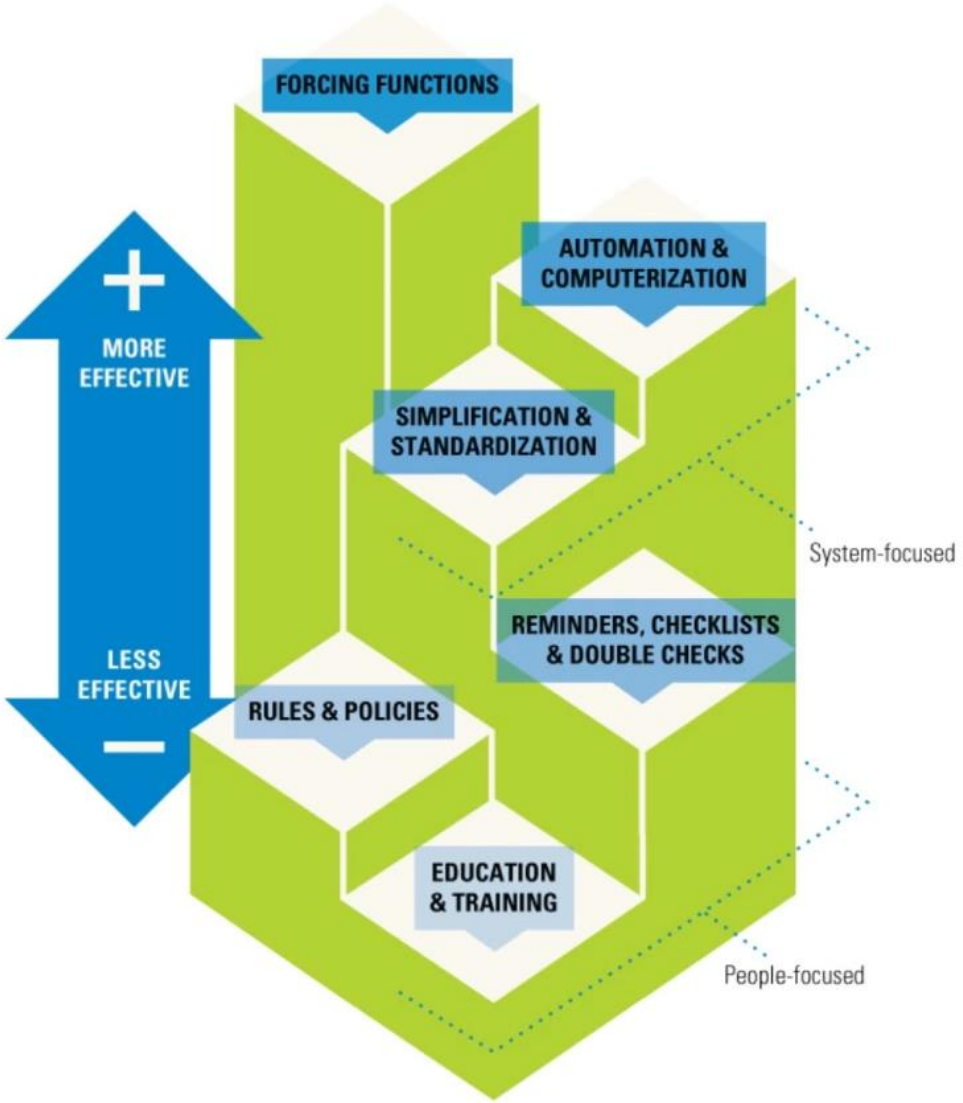
- Safety-I thinking has dominated discourses surrounding healthcare quality and safety
- This has diverted attention away from the importance of practical expertise
- Safety-II (and complexity science) redirect our gaze towards the practical expertise and non-codified work that are crucial within complex systems

Objectives

At the end of this talk, you will:

- Be disappointed

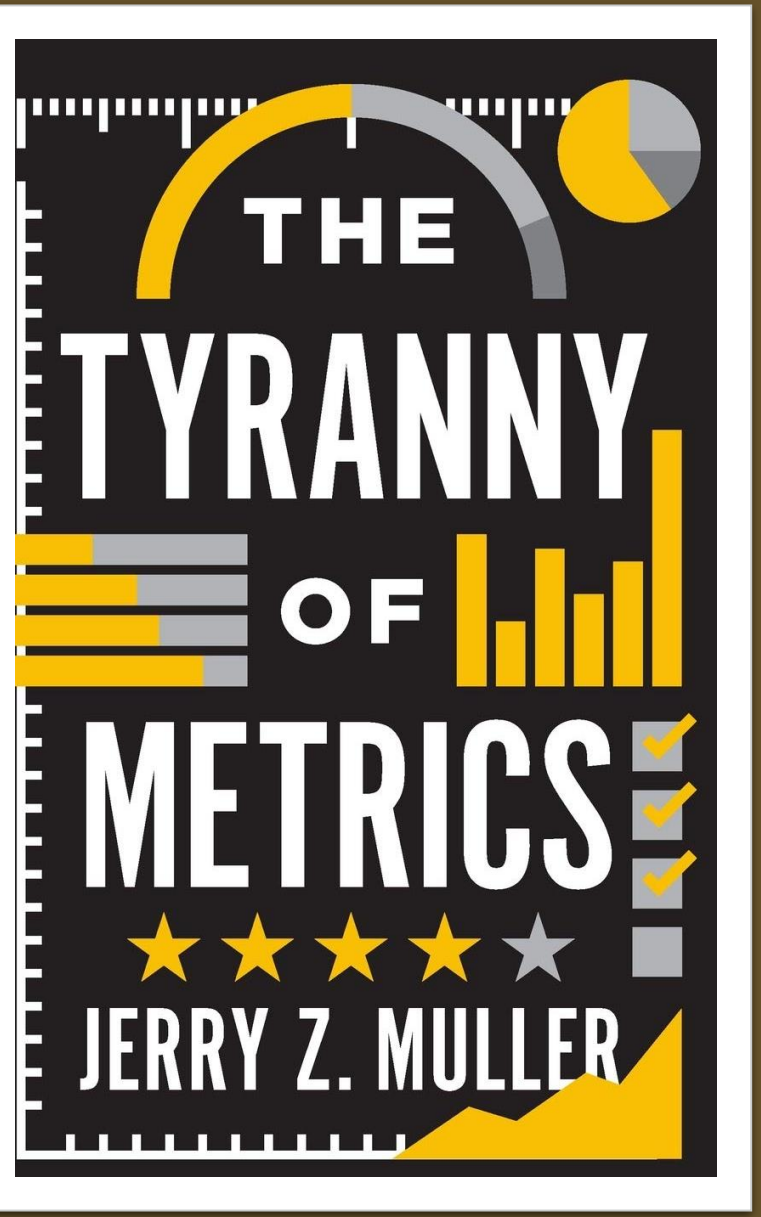
My Journey Through Healthcare Quality & Safety



"Every system is perfectly designed to achieve the results it gets"

Over the years…

- Vision of quality & safety did not match what I saw on the frontlines
- A “tyranny of metrics”
- Growing concerns with clinician wellness



Quietly…

Perspectives on Quality

Resilient health care: turning patient safety on its head†

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Moving towards a safety II approach

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Introduction

I have been studying safety in healthcare settings since the 1990s, predominantly in acute care settings and at a national policy level. There is a growing sense of unease do not seem to work. In this respect it is also really hard to convert policy into action. A complex system rarely responds to full scale change preferring incremental rather than transformative approaches.

Seeing patient safety 'Like a State'

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ABSTRACT

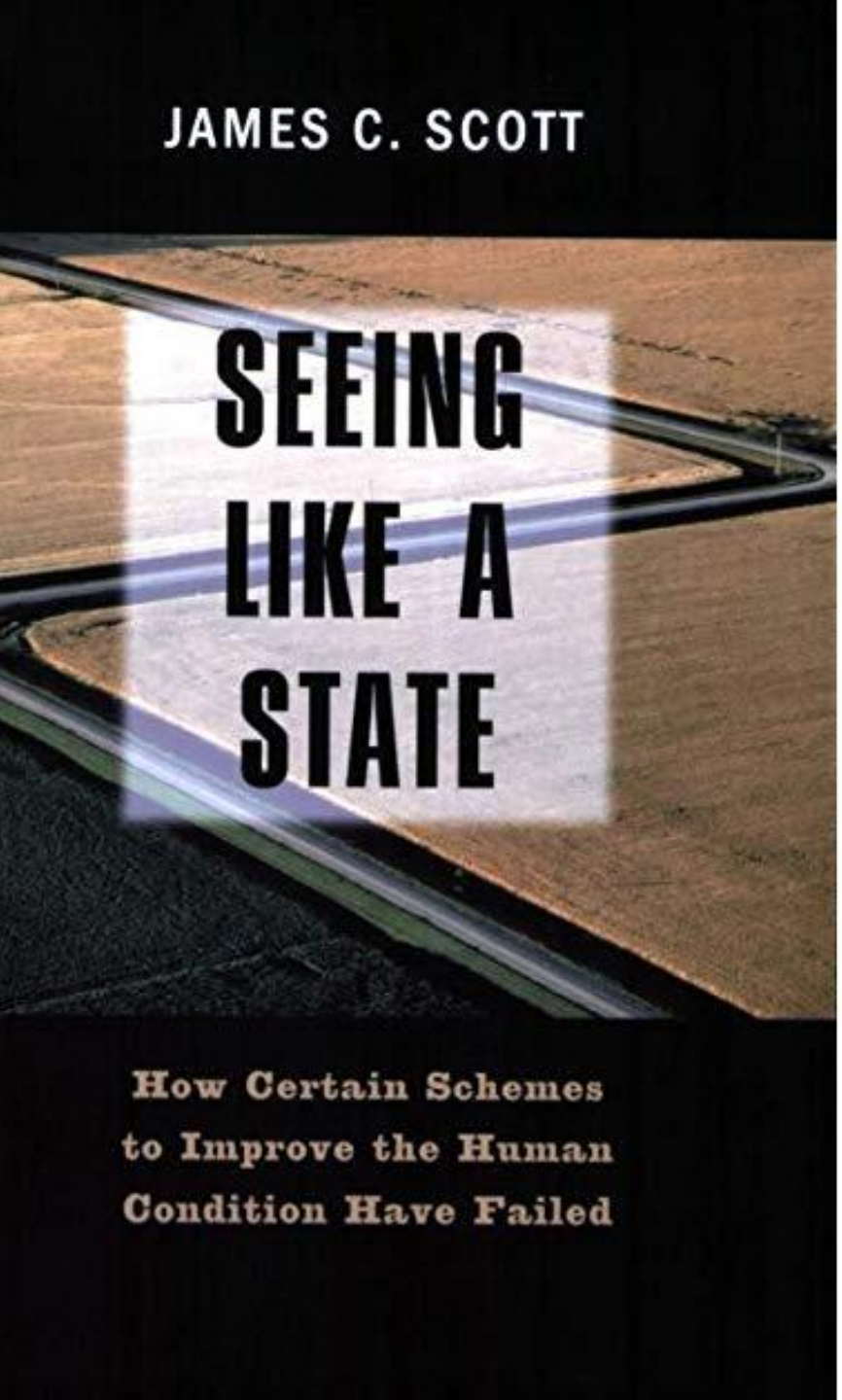
This paper examines how the syndrome of authoritarian high modernism, described in detail in the public policy sphere in James C Scott's *Seeing Like a State*, serves as the dominant, orthodox ideology informing patient safety. We compare Scott's conceptual framework to the currently dominant health care safety practices to surface foundational issues that would otherwise remain hidden, but which need to be revealed to make progress in safety. Although the paper focuses on safety in healthcare as a particular, specific exemplar, the elements of the syndrome are relevant to orthodox safety efforts in many hazardous activities.

	Safety-I	Safety-II
Definition of Safety	- As few things as possible go wrong - “Paradise Lost”	- As many things as possible go right - “Paradise Created”
Explanation of Problems	- Due to malfunctions and deviations (“root causes”)	- Outcomes are emergent (not resultant)
Purpose of Investigation	- Review incidents to find malfunctions & deviations so that they can be eliminated	- Learn from all events – what ”normal work” tells us about “incidents” and vice-versa
Attitude towards Frontlines	- Source of malfunctions & deviations	- Resource necessary for flexibility & resilience
Performance Variability	- Harmful, should be prevented	- Necessary, helpful; should be harnessed

Adapted from Hollnagel, 2014

- Could the dominance of Safety-I thinking in healthcare interfere with normal day-in, day-out work?

- Could the dominance of Safety-I thinking reveal some of the underlying mechanisms affecting the well-being of clinicians?



High Modernism

- Trumped-up belief in the use of scientific and technological knowledge to organize social systems
- Suggests the path to improvement is through legibility, rational design, and centralized oversight
- The fingerprints of high-modernism are all over contemporary healthcare
  - Safety-I approaches

Issue with High Modernism

- High modernism tends to marginalize practical knowledge and expertise
- Marginalizing practical expertise is a big issue in complex, socio-technical systems
- “…formal schemes of order are untenable without some elements of the practical knowledge that they tend to dismiss.” (Scott, 1998)

Why Safety-II Matters

- Brings practical knowledge and expertise back from the margins

The Road Ahead…

- Does Safety-II provide concrete, practical benefits in addition to any conceptual benefits?
- What does an effective balance of Safety-I and Safety-II look like?
- Is Safety-II possible in a system with high-modernist underpinnings?

Conclusions

- Safety-I thinking has dominated discourses surrounding healthcare quality and safety
- This has diverted attention away from the importance of practical expertise
- Safety-II (and complexity science) redirect our gaze towards the practical expertise and non-codified work that are crucial within complex systems