Emotional safety *is* patient safety

Audrey Lyndon ![ORCID],[1] Dána-Ain Davis,[2] Anjana E Sharma ![ORCID],[3] Karen A Scott ![ORCID] [4]

![Linked]

► http://dx.doi.org/10.1136/bmjqs-2022-014695

![Check for updates]

A growing body of research on patients' and families' understanding and conceptualisation of patient safety[1 2] begs the question of how and why we, in healthcare and the field of patient safety and quality, conceptualise patient safety as a domain separate from patient-centredness and patient experience.[3] In this issue, Archer *et al* contribute to this body of work.[4] The authors explored patients' conceptualisation of safety across three UK teaching hospital inpatient specialty wards in a qualitative interview study with a purposive sample of 24 English-speaking patients, 8 each from gerontology (medicine for the elderly), elective surgery and maternity (postnatal) wards. The authors found that patients in their study conceptualise safety as 'feeling safe' rather than 'being safe', and present a model of actions (performed, received, shared and observed) at the levels of self (patient), staff, family and friends, and the organisation that contribute to patients' 'feeling safe'. The study findings are consistent with prior studies indicating patients conceptualise safety differently from clinicians and that from the patients' and families' perspective; 'patient experience' and 'patient safety' are fundamentally intertwined.[5–7] Archer *et al* argue for the development of a new multistakeholder paradigm to include a deep understanding of 'what matters to patients to feel safe in hospital', that is, 'feeling safe'; yet they maintain a distinction between 'feeling safe' and 'being safe,' where only 'being safe' is characterised by minimising the risk of patient harm.

We fully endorse the need for changing the paradigm in patient safety. We endorse this need from our positions as patient safety and quality experts, as researchers, as health workers and as consumers—meaning as patients, as loved ones and as caregivers of people receiving medical treatment who have experienced disrespect, dismissal, medical racism,[8] near-misses and patient harm. However, we argue that limiting the conceptualisation of the patient's perspective on safety as 'feeling safe' while maintaining a distinction between 'feeling safe' and 'being safe'—which remains the norm in most patient safety and quality programmes—presents several problems. First, the differentiation between 'feeling safe', as defined through patient experience, and 'being safe', as defined through observation and evaluation using clinical outcomes selected by quality experts and health plans, creates a power differential and dynamic that degrades the role and value of patient experiences as valid patient safety indicators. The characterisation of 'feeling safe' can be easily dismissed—and has been dismissed—as not a 'real outcome' of interest to patient safety professionals.[6 9] Second, this framing minimises patients' perspectives on safety as subjective truth (eg, the 'feeling') not related to patient safety. Yet patients' perspectives on safety are generated by the experiential truth of the patient and family's trajectory of real, impactful and often harmful experiences navigating health systems.[9–11] These perspectives therefore belong squarely within the domain of patient safety. Third, the health system's prioritisation of 'being safe' over 'feeling safe'—despite some recognition of environmental factors—lends itself to keeping the focus on the responsibilities of the patient, the patient–clinician dyad and the immediate healthcare team rather than lending itself to a systems-level focus and approach. Fourth, the conceptualisation of 'being safe' as limiting safety to the absence of physical harm fails to characterise the corresponding harm

that can occur when patients 'feel unsafe'. Both the antecedents and the consequences of feeling unsafe are forms of emotional harm.[10] To characterise the corresponding harm, we must consider the very real structures, policies, actions and behaviours leading to 'feeling unsafe' as well as the consequences of 'feeling unsafe'. Not least of these consequences are fear, mistrust, medical trauma, loss of confidence in the healthcare provider and/or healthcare system and decreased healthcare utilisation.[11]

There is ample evidence of the ways in which patients are made to feel unsafe in healthcare. Patients routinely experience disrespect, may have their physical autonomy violated while in a structurally vulnerable position, have their concerns dismissed, and be subjected to abuse, racism, sexism, and classism.[9 12–16] We assert that violations of autonomy, dismissal of concerns, medical abuse, racism, sexism and classism in healthcare should be considered 'never events', comparable with the existing exemplars of never events, to better understand and bridge the gap between 'feeling safe' and 'being safe'. Accounting for emotional harms as 'never events' is one step towards addressing the gaps created by relying on a patient safety paradigm that undermines and ignores patient expressions and experiences of 'feeling safe'. Likewise, expansion of the terminology and types of 'never events' shifts the measurement selection and monitoring strategies from traditional, hierarchical, biomedical foci and frameworks. What we gain is a more contemporary, patient-focused, and human-centred experience and evaluation of safety that values misdiagnosis, delays in care, denial of access, disrespect, untreated pain, and failure to recognise clinical deterioration as defined for, by, and with patient and community experts.[14 17 18] Such events do not occur in a vacuum, but as part of a system that performs as designed: to prioritise medical expertise, technology, efficiency and revenue. A more expansive and inclusive definition of harm within the existing patient safety paradigm must recognise and act upon the reality that dismissal, disrespect, abuse, class bias, ableism, fatphobia, racism, sexism and transphobia in healthcare all exemplify failure to see patients as whole human beings who are experts on their own bodies and experiences, deserving of dignity and respect. The ongoing failure of health systems to honour the humanity of patients and communities in the provision of health and human services speaks to the cultural arrogance embedded in health systems design, provision, and evaluation that is fundamentally harmful and must be addressed.

The structural and systemic exclusion of patient experiences and community wisdom in establishing the norms and narratives of emotional and cultural safety discounts the credibility of patient expressions and experiences of safety in the definition and evaluation of patient safety. This results in two types of epistemic injustice, which occurs when people or groups are wronged in their capacity as knowers.[19] Testimonial injustice occurs when prejudice combined with power differential undermines patients' perceived credibility. Hermeneutical injustice occurs when patients and their communities of origin are not afforded full participation in generating shared meaning and measurement selection in the safety and quality arena, rendering them incapable of making sense of their own experiences, and of having those experiences understood by others.[19 20] Currently, epistemic injustice is deeply embodied and embedded in the patient safety field's normative foci. Existing patient safety meanings and measures reflect the structurally and historically dominant ways of being, doing and thinking, maintaining a hierarchy of knowledge value based on differential power between the quality-safety professionals and the public. Despite occasional recognition of the potential for psychological harm, existing operationalisations of patient safety largely fail to recognise the possibility of violating a patient's emotional safety while avoiding physical harm. The failure to operationalise a broader, more inclusive, patient community-focused patient safety definition facilitates testimonial and hermeneutical injustice. Thus, the argument that 'being safe' as an outcome measure defined as avoiding physical harm supersedes 'feeling safe' as an experience measure limits recognition of human dignity and undermines the capacity of measurement selection and monitoring strategies to provide both scientifically and culturally rigorous[15] information about the safety of care provided to patients, particularly structurally minoritised and marginalised patients.

Obstetric racism is an exemplar. Obstetric racism, as a phenomenon and analytic, best captures the unique experiences and conditions of Black mothers and birthing people's reproductive and perinatal care during pregnancy, labour and birth at the intersection of obstetric violence (reproductive dominance and control of people with capacity for pregnancy) and medical racism (individual, institutional and structural responses to a patient's race influence medical professionals' perceptions, treatments and/or diagnostic decisions).[17] Obstetric racism, rooted in histories of scientific racism and US chattel slavery that have infiltrated obstetrics and gynaecology, denies the decision-making capacity of Black mothers and birthing people resulting in provision of inaccurate and inappropriate medical assessments, treatments and counselling based on anti-Black racialised and gendered discrimination and stereotyping of Black women and birthing people. Obstetric racism is an adverse event that both creates and facilitates emotional, sociocultural and physical harm, violating patient safety. Obstetric racism also serves as an analytical

framework that connects the mistreatment, abuse, and neglect of Black mothers and birthing people during contemporary obstetrics care to the legalised oppression, dehumanisation, and degradation of Black people during chattel slavery and colonisation. Feeling safe or unsafe must be both determined and measured by the systems of healthcare and the language or behaviours of the healthcare workforce that reproduce the six dimensions of obstetric racism: ceremonies of degradation; coercion; diagnostic lapses; intentionally causing pain; medical abuse; and neglect, dismissiveness or disrespect.[16] Responding to acts of obstetric racism with prevention and mitigation strategies requires structural and systemic transparency, truth-telling, and trust in patient and community reports of feeling unsafe even within the context of achieving what professionals and experts in quality improvement and implementation science define as patient safety—that is, absence of defined medical error and specific classes of resulting physical injury. Operationalising obstetric racism as an adverse event and translating obstetric racism into a valid patient-reported experience measure of obstetric racism shift the power of knowing from quality and safety professionals to Black mothers and birthing people.[14] Naming obstetric racism as a patient safety violation illustrates the power and potential of amplifying patient voices and community wisdom in patient safety programmes and reconciles the harm and inhumanity of epistemic injustice.

Physical outcome measures as key provider and system performance indicators of patient safety fail to capture how well or how poorly patients and communities—particularly structurally minoritised and marginalised patients and communities—feel seen, heard, supported, wanted, celebrated, and safe during care design, provision, evaluation, and training.[15] Being safe extends beyond the avoidance of adverse events traditionally defined and measured as medication errors, accidental punctures or lacerations, falls, retention of a foreign body or wrong site surgery. Prioritising physical safety over emotional safety, particularly among the most structurally and systematically marginalised and minoritised patients, creates and sustains the byproducts of stigma (healthcare staff and institutional) and shame (internalised stigma at the individual level). Consequently, the perpetrators of harm, hurt, stigma and stigmatisation are then protected and even incentivised by the very system that is supposed to protect patients and hold individuals within the organisation accountable to the provision of care in an emotionally just and safe culture of care. The deprioritisation of emotional safety in the ethics and epistemology of patient safety by healthcare architects, administrators, providers, financiers and evaluators makes all complicit in a longstanding policy and practice of epistemic injustice, widening the gap between hospitals' stated intention to provide safe, high-quality care, and community experience of quality and safety. More importantly, the systemic and structural exclusion and/or erasure of patient experiences and community wisdom in shaping terminology, meanings and measurement selection further silences patient voices and undermines patient agency and self-efficacy.

Traditional patient safety meanings and measures frequently miss the mark in serving patients and families by ignoring or denying harms that patients and community members continually call us to acknowledge and address. Current efforts to support equitable patient participation in patient safety programmes will come up short if safety experts continue to define safety using a limited, traditional biomedical model, and ignore the central role of emotional safety. When we consider building an epistemology of patient safety with accountability measures and mechanisms that include both 'feeling safe' and 'being safe', the framework for patient safety is more robust and inclusive. The inclusion of patient-reported experiences of safety as defined by patients and families implicates the present healthcare system as deficient in preventing harm. To date, no mandate exists that requires systems to trust or rely on patient expressions and experiences of safety and harm as valid measures of safety and harm, and when patient experiences are considered, the measurement parameters are often defined by the institutional perspective on what counts as safety. The full integration of emotionally just safety practices and programmes cannot wait for the stubbornly slow and often ineffectual closure of the evidence-to-practice gap. Dramatic, visionary overhauls are needed, ones that demand widespread development and implementation of co-created models of patient safety with community, patients and transdisciplinary scholars. The patient safety field must simultaneously integrate critical race, feminist and disability justice theories such as obstetric violence, misogyny, obstetric racism and misogynoir (misogyny directed towards Black women based on racism and gender oppression) into their ethical, theoretical, methodological and dissemination approaches. Patient safety practitioners, clinical leaders and health system executives must also acknowledge power relations, differentials, and dynamics in the implementation, spread, and scale of conceptual models of naming, measuring, monitoring, and mitigating adverse events through understanding that feeling safe is a core component of being safe. So much is needed to truly transform healthcare into locations of actual well-being and healing, free of harm and hurt.

Harm is harm. Emotional safety *is* patient safety.

ORCID iDs
Audrey Lyndon http://orcid.org/0000-0003-2215-4273
Anjana E Sharma http://orcid.org/0000-0001-5541-2414
Karen A Scott http://orcid.org/0000-0002-6237-664X

REFERENCES

1 Coombs MA, Statton S, Endacott CV, *et al*. Factors influencing family member perspectives on safety in the intensive care unit: a systematic review. *Int J Qual Health Care* 2020;32:625–38.

2 Stern RJ, Sarkar U. Update: patient engagement in safety: AHRQ psnet. 2018. Available: https://psnet.ahrq.gov/perspective/update-patient-engagement-safety

3 IOM. *Crossing the quality chasm: a new health system for the 21st century*. Washington, D. C: National Academies Press, 2001.

4 Barrow E, Lear RA, Morbi A, *et al*. How do hospital inpatients conceptualise patient safety? A qualitative interview study using constructivist grounded theory. *BMJ Qual Saf* 2023;32:383–93.

5 Lyndon A, Malana J, Hedli LC, *et al*. Thematic analysis of women's perspectives on the meaning of safety during hospital-based birth. *J Obstet Gynecol Neonatal Nurs* 2018;47:324–32.

6 Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open* 2013;3:e001570.

7 Rosenberg RE, Rosenfeld P, Williams E, *et al*. Parents' perspectives on "keeping their children safe" in the hospital. *J Nurs Care Qual* 2016;31:318–26.

8 Hoberman J. *Black and blue: the origins and consequences of medical racism*. University of California Press, 2012.

9 Sokol-Hessner L, Folcarelli PH, Sands KEF. Emotional harm from disrespect: the neglected preventable harm. *BMJ Qual Saf* 2015;24:550–3.

10 Hall MF, Hall SE. When treatment becomes trauma: defining, preventing, and transforming medical trauma. *Proceedings of the American Counseling Association* 2013;2013:73.

11 Prentice JC, Bell SK, Thomas EJ, *et al*. Association of open communication and the emotional and behavioural impact of medical error on patients and families: state-wide cross-sectional survey. *BMJ Qual Saf* 2020;29:883–94.

12 Afulani PA, Kirumbi L, Lyndon A. What makes or mars the facility-based childbirth experience: thematic analysis of women's childbirth experiences in western kenya. *Reprod Health* 2017;14:180.

13 Davis D-A. Reproducing while black: the crisis of black maternal health, obstetric racism and assisted reproductive technology. *Reprod Biomed Soc Online* 2020;11:56–64.

14 Sharma AE, Mann Z, Cherian R, *et al*. Recommendations from the twitter hashtag # doctorsaredickheads: qualitative analysis. *J Med Internet Res* 2020;22:e17595.

15 White VanGompel E, Lai J-S, Davis D-A, *et al*. Psychometric validation of a patient-reported experience measure of obstetric racism© (The PREM-OB Scale™ suite). *Birth* 2022;49:514–25.

16 Scott KA, Davis D-A. Obstetric racism: naming and identifying a way out of black women's adverse medical experiences. *Am Anthropol* 2021;123:681–4.

17 Davis DA. Obstetric racism: the racial politics of pregnancy, labor, and birthing. *Med Anthropol* 2019;38:560–73.

18 Lyndon A. Failure to rescue, communication, and safety culture. *Clin Obstet Gynecol* 2019;62:507–17.

19 Fricker M. *Epistemic injustice: power and the ethics of knowing*. Oxford University Press, 2007.

20 Scott KA. The rise of black feminist intellectual thought and political activism in perinatal quality improvement: a righteous RAGE about racism, resistance, resilience, and rigor. *Feminist Anthropology* 2021;2:155–60.