Psychological safety in medicine: what is it, and who cares?

Psychological safety is a contemporary concept which refers to an individual's perception of the consequences of taking an interpersonal risk. Such an environment allows individuals to feel comfortable being themselves, expressing concerns, asking questions, and offering innovative ideas without fear of backlash or ridicule. Originally explored by Professor Amy Edmondson of Harvard Business School in the late 1990s, the concept was rooted in the observation that successful teams often made more mistakes than less successful ones, simply because they were more open about discussing and learning from those errors.[1,2] This insight has gained traction to become an achievable cornerstone of high performing teams, effective leadership, and vibrant organisational cultures in the business world, but has not yet permeated our discipline of medicine.

The traditional hierarchical structure of medical teams, combined with the high stress, time-sensitive nature of critically unwell patients, has contributed to an uptake lag within our industry. Unsurprisingly, the image of an infallible senior surgeon presents a challenge to open, two-way communication by suppressing voices, stifling critical insights, or preventing innovative suggestions.[3] However, as we recognise systemic failures relating to staff wellbeing and the impact of burnout after the COVID-19 pandemic, now is the opportune moment for us to integrate the basic principles of psychological safety to improve our culture. This is a pressing issue for all, because burying our heads in the sand has been shown to negatively affect patient outcomes.[4,5]

In laparoscopic gallbladder surgery, bile duct injuries continue to produce significant morbidity and costly medico-legal sequelae. Interestingly, if an operating surgeon encourages feedback from their assistant, the risk of bile duct injuries can be reduced.[6] It is well established in the literature that there are complex, inter-related barriers to achieving such psychological safety in the health care setting. At an organisational level, these include inadequate training and development, absence of reporting systems, and resource constraints. Team barriers include unfamiliarity or poor team cohesion, lack of clear communication protocols, and hierarchy and power dynamics. On an individual level, high workload, knowledge deficit, fear of repercussion or alienation, cultural or gender differences, and ego and perceived superiority are the common factors. Undertaking and interpreting research in health care settings is plagued by heterogeneity of study design, concept implementation, endpoint assessment, and reporting. To their credit, disciplines such as nursing, anaesthesia and emergency medicine contribute the bulk of the psychological safety literature, recognising its significance in enhancing team dynamics and patient outcomes.[5,7]

In implementing any form of change, developing a multipronged approach provides the best chance of success. A clever project title or acronym is also handy.[8] Continual emphasis throughout this process must be placed on the ultimate vision, which is an environment of trust, openness, and mutual respect.

The first prong, and perhaps the pointiest, is commencing change at an institutional level. Government bodies and hospital administration play a crucial role in shifting the existing landscape toward psychological safety; an inquisitive assessment of the unique pressures and challenges faced by various stakeholders is required, followed by development of actionable steps.[2] On a global scale, Australia is considered a frontrunner in attempts to introduce this very attainable concept, as evidenced by a new Australian government-backed initiative, A Better Culture (https://abetterculture.org.au/about-us/), launched with the goal of stamping out harassment, racism and discrimination from the health care industry. Furthermore, it is slowly filtering into leadership training resources of health managers and team leaders.[9]

The next prong is providing an atmosphere of open communication, where all team members — regardless of hierarchical position — feel empowered to speak up without fear of ridicule. Scarcity of trainee jobs and highly competitive specialty programs indirectly create a mentality among juniors that silence is better than being viewed as a problematic team member. Safe Work Australia develops national regulations for all industries to ensure that employers identify and eliminate psychosocial hazards, which would include traumatising derision in hospital corridors or department meetings. Encouraging team members to voice concerns, observations or suggestions, especially during critical moments of patient care, can be facilitated through a regular pre-operative time-out or "huddle", or debriefings following critical events. These sessions allow for the discussion of potential challenges, clarification of roles, and reflection on successes and areas for improvement. Integral to this is the deconstruction of the hierarchical pyramid, such that all team members are comfortably viewed as equal human beings.[10] A simple evidence-based strategy to achieve this is communication using first names of all staff members, without requiring the rigid formality of title and last name.[11]

The final prong has been a mainstay training tool used by our critical care colleagues: regular training and simulation education. Training sessions can display the importance of psychological safety within common clinical scenarios, its impact on patient outcomes, and practical strategies to enhance it. For example, role-playing simulations allow team members to practise the exact wording required to voice concerns or provide feedback in a controlled

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environment.[12] Training sessions are also the opportune time to educate staff about reporting mechanisms for escalation of concerns and errors. A no-blame approach shifts the focus from individual blame to systemic improvement, encouraging teams to learn from mistakes rather than concealing them. Recognition of the high stress and emotionally draining toll of health care also requires education on available counselling services for maintenance of mental and emotional support. Of course, one must concede that orchestrating such systemic cultural shifts will be a gradual process and must factor in regular feedback from all stakeholders. Consistently valuing and acting upon the input of all members reinforces the ultimate founding principle of psychological safety that every voice matters.

As we emerge from the post-pandemic ashes, it becomes unequivocally clear that our own wellbeing — and the outcomes of our patients — relies not just on our clinical acumen or brilliant surgical technique, but also on a host of intangible cultural constructs that need upgrading. Psychological safety has remained on the periphery of the health care world, but now is the time to give it the attention it clearly deserves.

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