Podcast 6 - Seeking Safety: Support for a "Speak Up" Culture in Health Care

Transcript

[Jazzy instrumental intro music]

[Voiceover] Michael Konstan: Welcome to Cardi-OH Radio, a podcast of the Ohio Cardiovascular Health and Diabetes Collaborative, also known as Cardi-OH. This is Dr. Michael Conston from the Case Western Reserve University School of Medicine, and I serve as a principal investigator for Cardi-OH, a statewide network of Ohio's seven medical schools. Cardi-OH is funded by the Ohio Department of Medicaid and shares best practices to improve cardiovascular health and diabetes outcomes and to eliminate health disparities in Ohio's Medicaid population. I hope you enjoy today's podcast.

Aleece Caron: I am Aleece Caron, practice improvement coaching lead for Cardi-OH's team best practices and associate professor of medicine at Case Western Reserve University. Today's podcast will address the importance of creating a climate of psychological safety in the healthcare setting. With roots in organizational psychology and studied in multiple sectors, psychological safety has been a key focus of patient safety initiatives supporting a "speak up" culture in order to reduce medical errors, promote teamwork, and retain an engaged clinical workforce. With me today is Dr. Michael Holliday. Dr. Holliday is an assistant professor of family and community medicine and the medical director of the student health center at the University of Cincinnati. He completed both his medical degree and residency at the University of Cincinnati. For the last 20 years, Dr. Holliday has delivered primary care to Medicaid patients. His interests include medical education, improving hypertension outcomes and care, and enhancing joy of work in healthcare. He recently served on an advisory board for the Health Policy Institute of Ohio's call to action regarding clinician well-being and patient care and safety. Welcome, Dr. Holliday.

Michael Holliday: Thank you. It's a pleasure to be here.

Caron: In order to set the stage for this podcast, I'd like to share a quote from Dr. Amy Edmondson, Harvard Business Professor and author of The Fearless Organization: "People are both the sensors who pick up signals that change is necessary and the source of creative new ideas to test and implement". After listening to this podcast, you should be able to explain the difference between information about psychological safety in the evidence-based literature and popular misconceptions about the topic, identify the impact of psychological safety's presence and absence within a team that is striving to improve their work, and identify the roles of individual team members and team leaders to create an environment of psychological safety. Psychological safety has been described as early as the 1960s and studied extensively in healthcare as well as settings like the auto industry, aviation, and NASA. What is psychological safety and how is it different from what one might think of when hearing this term?

Holliday: When I first heard psychological safety as a term, I assumed it was maybe an individual experience like "I feel safe" or that things are conflict-free, or maybe it's a personality trait like "I'm a nice person". But looking at the research Amy Edmondson has reviewed, it's not an individual experience or a trait, but actually a quality of the working environment. It's a quality that encourages team members to speak up with valuable information for the team's work without fear of negative consequences.

Caron: Based on research, what happens when psychological safety is low?

Holliday: Research shows that psychological safety is actually rare. Most workers recall a time they did not speak up because they feared negative consequences, such as being viewed negatively or damaging interpersonal relationships. When this lack of safety is part of the culture, team performance tends to decline, people become less engaged, and safety tends to be worse in healthcare settings.

Caron: So, Dr. Holliday, could you give us an example of what happens when psychological safety is low?

Holliday: In healthcare, work is often unpredictable and interdependent, making communication extremely important. When people don't feel free to speak up, you miss valuable information. For example, if a leader tries to improve a process that people know isn't working, they might stay quiet because they don't want to "call the leader's baby ugly". They'll say it sounds great, but then the implementation fails because it was never going to work in the first place.

Caron: How does psychological safety impact day-to-day work in healthcare?

Holliday: Research shows teams perform better. A concrete example is Project Aristotle, a study at Google which showed that psychological safety was far and away the most predictive characteristic of team effectiveness. It also encourages learning. In quality improvement, failure is feedback; when safety is present, people see a less-than-ideal outcome as feedback to improve rather than a "horrible failure". Interestingly, teams with high psychological safety actually report errors more often. While they tend to have fewer total errors, the reporting is higher because people feel comfortable doing so.

Caron: Could you expand on how it affects day-to-day work?

Holliday: With psychological safety, you can have open communication about the day's demands and the limited resources available to meet them. Without that, individual team members may avoid being the "messenger of bad news" regarding patient complaints or safety concerns and may instead rely on individual workarounds rather than working with the team.

Caron: And how would it affect quality improvement activities?

Holliday: Quality improvement is like "building this plane while it's flying in the air". Psychological safety improves communication in every phase of the QI process, starting with baseline process mapping. Without safety, people often can't even agree on what the current process is because they feel bad about how it's going. It also helps in aligning on the aim (what we are trying to do) and the measures (ensuring they are fair and useful). Finally, it helps get ideas for improvements that won't disrupt the day's work.

Caron: How is psychological safety impacted in each phase of a PDSA (Plan-Do-Study-Act) cycle?

Holliday: It's critical in every stage, but most critical in the planning part. We had an issue in one of my offices where people were upset about patients arriving late. Some wanted a hard rule to send them home, but through a long discussion in the "Plan" section, we looked at it as more than an inconvenience; it was a safety and patient satisfaction issue. We needed psychological safety for everyone to agree on all the issues involved.

Caron: Can you provide another example of how this is impacted in QI work?

Holliday: As a medical director, I was trying to improve how we handled late patients. It was a "hot button issue" with a lot of emotions. I was most concerned about safety, but I had to listen to staff who were worried about the flow of the clinic. Once we got on the same page and aligned our goals, we started measuring. It turned out patients weren't late as often as we thought. This engagement allowed us to create a clear triage process that made it easy for front staff to collect information and ensure safety.

Caron: How do you foster that culture of trust in practice?

Holliday: It starts with assuming the best in people—assuming everyone wants safety and a good experience for the patient, even if their perspective is different from mine. It's a balance of listening and making it safe to speak up while still challenging the team to recognize that the work is complicated and important.

Caron: Since we need it, how do we get it?

Holliday: It isn't easy; it takes work. Every individual feels a tension between the risk of a negative response and the risk of not speaking up. Since childhood, we are trained to manage our image—we don't want to look stupid, be disliked, or be disruptive. Leadership must manage a tension too: providing safety while maintaining the challenge of important work. Amy Edmondson suggests "setting the stage" by framing the work as unpredictable, complex, and error prone. This makes speaking up feel like an obligation for patient safety.

Caron: What are some other leadership strategies?

Holliday: "Going first" is very successful. I used to share "marvelous mistakes" in office meetings—embarrassing times when things didn't work out—to show that admitting imperfection is okay. Another step is inviting participation by asking good questions. Instead of asking "Were there any errors?", ask "Was everything as safe as you wanted it for your patients?". This accepts that things aren't perfect and encourages ownership. Finally, leaders must respond productively. We must thank people for feedback, even if it's not what we want to hear, to ensure they do it again. We can still give constructive feedback on how to communicate, but we must respond to information with action.

Caron: Thank you, Dr. Michael Holliday, for joining us and providing such clear examples. And thank you to our listeners.

[Voiceover] Konstan: This concludes today's podcast. Be sure to visit Cardi-OH.org to learn more.

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