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Institutional CUREiosity, Safety Reporting in Healthcare.

To Err is Human (IoM, 1999) was instrumental in promoting Safety Reporting Systems as a key organisational learning tool in healthcare. After its publication learning and reporting systems became seemingly indispensible, ever-present tools of the Safety-I approach to patient safety. More recently, they have become subject of growing criticism on account of their limited success (Sujan).

Within the context of Safety-II reporting systems seem outmoded and expandable. The emphasis is on performance variability, on front-line workers' capacity to adapt. As the focus shifts onto how things go right in every day clinical practice how things go wrong is of little relevance. Reporting and learning systems seem an extraneous distraction.

Healthcare faces particular challenges in understanding how front-line staff adapt their practice. Unlike other safety critical industries, healthcare largely lacks contemporaneous records of work-as-done.

According to Dekker (2012) 99.9% of activity in aviation is monitored, generating "immediate and almost exhaustive evidence," real, verifiable data. In healthcare, in contrast only an estimated 0.1% of patients are enrolled in clinical trial. We lack evidence for 99.9% of "procedural, clinical or pharmaceutical interventions". Reporting systems in Aviation are add-ons, valuable textual data to complement the wealth of available monitoring data.

In healthcare on the other hand patient and staff reports are (be it incidents, hassles or excellence reporting), at times the only available records of front-line care.

What are the tools for understanding work-as-done in healthcare, how can we systematically capture performance variability and everyday trade-offs as healthcare staff balance thoroughness and efficiency? How do we make sense of records of personal experience?

These questions are central within the Safety-II context.

Reporting systems in healthcare are particularly potent but also particularly challenging. Because most healthcare work occurs in unmonitored, evidence free zones, often all we have are personal reports. Thereby rendering a structured and systematic approach to analysis particularly important.

Whether the focus is on what goes wrong or on what goes right, the evidence on which our understanding is based are textual representations of 'what happened' seamlessly interwoven with 'how it felt' (Iedema, a.o.). Established analytical methods (mainly statistical analysis) in safety reporting sideline this tension accepting reports at face value, overlooking the complex textual nature of this evidence.

But reports, and thereby reporting systems are marked by a tension between a rationalising intent and the affective-moral dimension of narratives (Iedema, a.o.). Acknowledging and working with this tension is central to ensuring that our understanding of front-line work is nuanced and insightful.

While this tension between rationalising and affective dimension of personal narratives are unchartered territory for Safety Sciences, it is the central focus of textual analysis and in particular hermeneutic analysis (text interpretative methodology embedded in three centuries of philosophical tradition (not to mention its roots in Ancient Philosophy and Talmudic Scholarship).

We developed Institutional Cureiosity as a systematic approach to acknowledging and embracing these tensions and to analysing reports as texts rather than incidental data for statistical analysis. Our work builds on Applied Hermeneutic Methodology as developed by John Davies and team for CIRAS for Scottish Rail (2003). Which in turn took up D.H. Taylor's 1981 critique of the mechanistic model of safety "The hermeneutics of accidents and safety".

As both the CIRAS team and we discovered when working within a Safety-I context introducing Hermeneutics and the underlying epistemology can be extremely challenging.

Effective reporting is predicated on high levels of trust within the organisation ensuring that staff feel confident and comfortable to disclose the reality of their work-as-done. Healthcare environments are often marked by a fundamental lack of trust. The recent case of Dr Bawa-Garba merely highlights the profound mistrust within healthcare system.

One of the key benefits of using hermeneutic methods within safety reporting is, that it embraces tension, by recognising conflicting perspectives rather than dismissing challenges.

Institutional Cureiosity in healthcare and Applied Hermeneutics are effective methods for improving our understanding of work-as-done especially, in relation to work-as-disclosed and work-as-imagined. Key challenges within the Safety-II context.

By presenting our experiences from our pilot work in Out of Hours Care using Institutional Cureiosity I would like to open up the discussion on how we can use reports to better understand work-as-done in healthcare in particular. And how we can systematically make sense of personal experience to grasp both performance variability and adaptive capacity.