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**Chapter**

# Social Work Leadership for Patient Safety

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## Abstract

Social workers are rarely considered as key personnel in the field of patient safety. The clinical nature of many, if not most, errors means that it is much more likely that doctors, nurses and pharmacists are involved both in the errors themselves and in attempts to improve the quality and safety of care. Yet, despite best efforts around the world for the last two decades the overall rate of errors has not decreased. In this chapter I argue that there is great potential for social work leadership to improve the quality and safety of care for patients and clients, and in particular for vulnerable individuals and groups. One way of understanding this potential is through the lens of a social epidemiology of patient safety, which can then be linked to the competencies required by social workers in leading this new approach to patient/client safety and quality improvement. Drawing on evidence both from research and from patient safety inquiries around the world, I look at how the social context and status of patients contributes to errors, particularly of vulnerable individuals and groups, and the unique leadership role that social workers can take in preventing and responding to errors and adverse events.

**Keywords:** patient safety, equity, leadership

## 1. Introduction

In this chapter I will explore the under-realized potential of social work leadership as a way of improving the quality and safety of care for patients and clients, and in particular for vulnerable individuals and groups. I begin by briefly examining what we know about patient safety, including the gaps to that understanding. I then explore a new approach to patient safety – one which draws from social epidemiology, ending with several ways in which social work leadership can contribute to increasing the safety and quality of healthcare through specific leadership competencies.

### 1.1 Patient safety

Patient safety is an enduring concern in healthcare as evidenced by the wording of the Hippocratic Oath, written in the second half of the fifth century BC, which speaks to the potential for harm caused by healthcare professionals and interventions [1, 2]. Indeed, several 'waves' of concern about the quality and safety of care have been identified over recent centuries, including Ignaz Semmelweis' attempt to reduce hospital

infections in the 19th Century [3], through to the 20th and early 21st centuries [4] and the development of clinical governance and related frameworks.

There is no doubt that the patient safety movement has gained momentum over recent decades, not least of all because of mounting evidence for the persistent rate of errors and adverse events [5]. While estimates vary across countries and service types, it is generally accepted that somewhere between 10 and 12% of people admitted to hospital will experience some form of adverse event [6]. Panagioti, Khan [7] for example found that least one in 20 patients suffer harm that is preventable with around 12% of preventable harm resulting in permanent disability or death.

In recent years the United States the Institute for Health Innovation (IHI) has developed what they originally called the triple aim of healthcare. This framework sought to accelerate the improvement of care by integrating (what were then considered to be the) three most important aspects of healthcare delivery, namely: improving patient experience; improving population health; and lowering per capita costs for healthcare [8].

Over time the IHI have added two more aims for healthcare systems. The first addition was ensuring clinician wellbeing (the quadruple aim) [9]. The most recent addition, in 2021, has been that of health equity move the framework to one of a quintuple aim [10]. Whether or not individual services or systems follow the IHI framework, it provides a useful insight into the nature of healthcare as a complex adaptive system, and the types of organizational and professional relationships that can operate to either facilitate or prevent errors [11, 12].

There are three issues which emerge from the current phase of the patient safety movement which we need to considered relation to the role of social work leadership in patient safety. The first issue is that the rate of adverse events has not decreased significantly despite two decades (and more) of effort around the globe. As Mannion and Braithwaite ([13], p. 685) argue "*... despite extensive efforts by many committed and well-intentioned policy-makers, managers, clinicians, researchers and patient groups, it is disconcerting that improvements in safety have been confined to a few celebrated examples or niche areas …. Where there have been solutions advanced, they have proved difficult to sustain and spread, with recent studies confirming there has been little or no measurable improvement in the overall rates of preventable harm at the systems level.*"

The second issue is that errors are categorized in two ways. They are either "*An act of commission (doing something wrong) or omission (failing to do the right thing) that leads to an undesirable outcome or significant potential for such an outcome.*" ([14], n.p.). Much more is known about errors of commission than errors of omission, although McGlynn, Asch ([15], p. 2635) that in their US study at least "*Participants received 54.9 percent … of recommended care*" meaning that just under a half of all patients were missing out on some type of intervention/assistance they should have received. What we also need to consider is Tudor Hart's inverse care law (after the UK general practitioner who first described this principle) which states that "*The availability of good medical care tends to vary inversely with the need for it in the population served*" ([16], p. 405). Iezzoni ([17], p. 2093) also warns about the particular risk for vulnerable groups, and in particular people with disabilities. She notes *that "People with disability experience health care disparities, including delayed diagnoses … Evidence suggests that these disparities often arise from erroneous assumptions health care providers make about the lives and values of people with disability*" – a perspective that was evidenced throughout the course of the COVID pandemic (as I will discuss later in this chapter).

The final issue is that few, if any, health systems or services collect systematic data on the type of patient who have experienced errors. This means that we do not have

a clear understanding of whether the prevalence or type of errors are the same for different groups, and topic which I will return to later in this chapter.

## 1.2 Leadership and patient safety

Leadership and patient safety are inextricably linked, particularly but not only, in relation to leaders' role in establishing and maintaining safety cultures [18] and providing oversight of service quality [19]. Our understanding of the type of leadership required to ensure the quality and safety of care has changed over recent years. The Agency for Healthcare Research and Quality ([20], n.p.) states that *"Although the concept of leadership has traditionally been used to refer to the top rungs of an organization, frontline workers and their immediate supervisors play a crucial leadership role in acting as change agents and promoting patient-centered care. As the safety field has evolved, there is a growing recognition of the role that organizational leadership plays in prioritizing safety, through actions such as establishing a culture of safety, responding to patient and staff concerns, supporting efforts to improve safety, and monitoring progress."*

Indeed in recent years, and as a result of numerous public inquiries into various patient safety failures, there has been a decided shift away from the concept of leadership as 'the tope rungs of an organisation' to the idea of distributed or systems leadership. The King's Fund in the UK recommended that "The old model of 'heroic' leadership by individuals needs to adapt to become one that understands other models such as shared leadership both within organisations and across the many organisations with which the NHS has to engage in order to deliver its goals. This requires a focus on developing the organisation and its teams, not just individuals, on leadership across systems of care rather than just institutions, and on followership as well as leadership" ([21], p. ix).

## 2. Reconsidering patient safety from a social work perspective

Patient safety is most often viewed as a technical endeavor, that is one with is focused on the identification, mitigation and response to risks and errors [22]. But beyond the technical aspect, there is also another dimension to patient safety, and one which has generally been 'hidden in plain sight'. That is that the as history shows certain groups have always been at higher risk of harm within healthcare systems and services, and those risks are not necessarily associated with the condition which is being treated, but rather with their social status.

One of the most popular ways to manage public distress over large scale failures of patient safety has been through public inquiries. Even a cursory glance at inquiries around the world show that particular groups – people with disabilities (particularly but not only those with mental illnesses), older adults, women are over-represented as the victims in these cases [23]. Such inquiries go back into the 1800s most often at that time into the treatment of patients in what where then known as 'lunatic asylums'. More recent inquiries range those into individuals who systematically murdered patients, as in the case of Harold Shipman (most of whose victims were older women) [24] to wholesale failures of governance as occurred in the case of Mid-Staffordshire Hospital in the UK, where many patients died not of medical errors but of de-hydration, that is because of a lack of human rather than technical care [25].

In a study conducted in NSW, Australia with 195 clinicians we asked who the clinicians thought were at risk of harm in the healthcare system. They identified the

following groups (in no particular order): clinicians; the older adults; Indigenous peoples; immigrants – especially those with limited local language skills; people with disabilities, especially people with cognitive impairments; children and youth; patients with literacy and communication problems; people from lower socio-economic backgrounds; geographically isolated individuals; socially isolated individuals; people who are homeless; the frail and malnourished; prisoners; patients with co-morbidities and chronic illness; patients with high acuity and complex system dependence (e.g. on dialysis); those with liminal (social, physical, geographic) status; and those patients without an advocate [26].

We replicated part of this study with a survey distributed through the International Society for Quality in Healthcare (ISQUA), that is to an international audience, 15 years later in 2018. In that (still unpublished study) 413 participants from around the globe identified a very similar list of groups including: older people, including frail older people and people with cognitive impairments; children, babies, newborns, 'young people'; patients in general, 'anyone in health care', 'vulnerable patients'; people with specific, complex or co-morbid medical conditions; people with cognitive impairment, learning problems or intellectual disability; health professionals and others employed in health facilities; people from culturally or linguistically diverse backgrounds, 'ethnic minorities'; people in specific areas e.g. ICU, emergency, surgery; people with mental health problems and or substance abuse; people with physical or sensory impairment; people with limited education and or literacy; poor people, low socio-economic status, 'underserved'; people unable to communicate; people with multiple medications; indigenous people; homeless people; pregnant women; people with no advocates in health system, 'no friends or family'; people with rare conditions; and women. The risk to the most vulnerable individuals and groups, it seems, has not abated and could help explain at least in part why the overall rate of errors is not falling.

Why are these groups at higher risk of harm? There are several inter-related issues that have been identified. As we noted in a series of literature reviews we conducted on this very issue Travaglia, Debono ([27], p. 6) *"Cascade iatrogenesis [28, 29], where one error leads to others, may be an additional risk for these groups, as may the effects of diagnostic overshadowing [30, 31], where a condition (e.g. a brain tumor) remains undi-agnosed because the clinician attributes the manifestations to another (e.g. mental) illness [32]. Understanding the complex and inter-related social factors that increase ill-health in individuals, groups and communities provides a starting point for understanding why, if, when and how people access and utilize healthcare, how ill they are when they do so, and how these factors might affect their susceptibility to medical errors and adverse events [33]."*

One way of diving deeper into understanding why these particular groups are at heightened risk of harm is through the lens of social epidemiology. Social epidemiol-ogy is *"... distinguished by its insistence of explicitly investigating social determinants of population distributions of health, disease and wellbeing, rather than treating such determinants as mere background to biomedical phenomena"* ([34], p. 693).

Kreiger's (2001) framework takes into account the: biological expressions of social inequality (that is the embodiment of experiences of socio-economic inequal-ity, which often result in poorer health across the lifespan for these groups); impact of discrimination; eco-social theories of disease distribution (i.e. population level patterns of health, disease and wellbeing); gender, sexism and sex; human rights and social justice; life-course perspectives; poverty, deprivation and social exclusion; psy-chosocial epidemiology (the health damaging effects of psychosocial stress); 'race'/ ethnicity and racism; sexualities and heterosexism; social and cultural perspectives

of health; social class and socioeconomic status; social determinants of health; effects of social inequality and inequity in health; social production of disease/political economy of health; social production of scientific knowledge; stress; and theories of disease distribution (across time and space) [34]. We have added ableism to the list Travaglia et al. (2019).

In 2019 we undertook literature reviews looking at the risk of harm for eight vulnerable groups: people from culturally and linguistically diverse (CALD) backgrounds; older people; lesbian, gay, bisexual, transgender, queer and inter-sex (LGBTQI+) people; First Nations peoples; people who are homeless; people living in rural and remote communities; prisoners; and people with intellectual disabilities.

*"Some studies found significantly higher risk of harm among the vulnerable groups. Instances of suboptimal care included: misdiagnosis; hospital-acquired infections; less active or inappropriate treatment; preventable readmissions; less frequent health screening; inappropriate prescribing; and poor communication between patients and providers with potentially damaging consequences. In addition to their underlying health needs, people in remote regions may experience less effective healthcare due to under-resourced services, distance to specialist care, or high turnover of health professionals. Some studies reported inadequate recognition and treatment of comorbid conditions, e.g. among people with intellectual disabilities.*

*Our researched showed the intersectional nature of the risk to patient safety, which multiplies with the number of vulnerable groups of which the individual is a member.*

*Studies highlighted the intersectional nature of patient safety, where individuals experience poor treatment because they belong to two or more vulnerable groups, e.g. First Nations people living in remote locations, or people with intellectual disability in prison. This compounds their vulnerability, increasing the risk within health systems. Studies also found some disadvantaged people reluctant to access health services, exacerbating their already poor health, due to negative previous experiences or fear of discrimination or disrespect"* ([27], pp. 3-4).

While the understanding of the causes of ill health from a social perspective goes back decades and is very well established, this approach has not widely been employed in understanding the causes of iatrogenic harm/illness. However looking at harm from this perspective provides additional insights not only into the causes but also into potential strategies to address these harm. This is where social work leadership could come to the fore.

## 3. How social work leadership can help improve the quality and safety of care: Especially for vulnerable individuals and groups

Social work leadership is important because if we accept the fact (and I used that phrase advisedly and carefully) that patient safety is about the social as well as the technical dimensions of care, then social workers can provide unique insights and leadership into the risks and responses to those dimensions. In this section I will look at five areas in which social workers can provide leadership in patient safety: clinical governance (and other safety frameworks); understanding the social dimension of risks; advocacy; interprofessional practice; and equity.

### 3.1 Clinical governance

Clinical governance emerged in the United Kingdom in the late 1990s as an approach to improving the quality and safety of care. It was developed at least in part as a response to major patient safety inquiries, especially the Bristol Royal Infirmary Inquiry into the higher than expected deaths in children who were undergoing operations for cardiac problems at that hospital. That inquiry found, as quoted by the British Medical Journal "... *poor teamwork between professionals, "too much power in too few hands," and surgeons who lacked the insight to see that they were failing and to stop operating.*" ([35], p. 181).

Clinical governance was defined as "*a system through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish*" ([36], p. 62). Many countries around the world, mostly but not entirely Commonwealth countries, have adopted all or some of the elements under a clinical governance approach. These elements include: "*accountability, vigilant governing boards and bodies, a focus on ethics and regulating qualified privilege. It also includes taking steps to institute measures such as continuous improvement, quality assurance, audit, applying standards and ensuring they are met, using clinical indicators, encouraging clinical effectiveness, promoting evidence-based practice, participating in accreditation processes, managing risk, reporting and managing incidents, focusing on patient safety, improving the sharing of information, supporting open disclosure, managing knowledge effectively, obtaining patient consent, providing feedback on performance, promoting continuous education, dealing with complaints effectively, encouraging consumers to participate in decisions affecting their care and credentialing of medical [and other] practitioners.*" ([37], pp. 12-13).

While not all countries' safety systems may include all of these elements, most have adopted at least some of them. Social workers can and should be involved both in ensuring that such systems are in place, and in participating in the review processes to ensure a wider lens is included in activities such a root cause analysis processes [38].

### 3.2 The social epidemiology of patient safety

One specific role for social workers to contribute to clinical governance (and related activities) is in explaining and exploring the way in which individual's and group's social characteristics make increase their risk of adverse events and harm. There are multiple examples of this, but I would like to discuss two in particular: the way in which risks do not just start and end with the clinical encounter and what is known as diagnostic overshadowing.

As I discussed earlier in this chapter, relatively little work has been undertaken by patient safety researchers about the way in which a person's social characteristics may increase their risk of harm. This increased risk can occur prior, during or after the medical intervention. Research has shown, for example, that malnutrition increases a person's risk of hospital acquired infection. Yet it is well known both that geriatric patients are more likely to enter hospital with malnutrition and that some patients, including children and older adults, are at risk of developing malnutrition while in hospital [39, 40]. Malnutrition is a pre-operative risk factor [41], but understanding and responding to this risk requires both general clinical knowledge and an understanding of the vulnerability of particular individuals and groups.

Another example of increased risk is patients discharging themselves against medical advice (DAMA), and therefore missing out on the care they require. It is easy to think 'it's their decision' but the reality is that for many vulnerable groups, the reasons are due to factors such as the affordability of care [42] or in the case of First Nations people, a lack of cultural safety [43].

Another specific risk which social work leadership can address is the effect of diagnostic overshadowing. Molloy, Munro ([44], p. 1363) define diagnostic overshadowing in relation to people with mental illnesses in the following way *"One form of discrimination is diagnostic overshadowing, which is a judgment bias where health care professionals mistakenly attribute clinical manifestations of physical illness (eg, pain, tachycardia, hypertension) to manifestations associated with a pre-existing mental illness … This leads to physical illnesses being underdiagnosed and undertreated … Common causes of diagnostic overshadowing related to health care professionals who care for mental health consumers include fear, avoidance, lack of education, lack of confidence, and lack of clinical assessment, including symptom recognition … and negative unconscious bias".* Cho ([45], p. 1) adds that *"Systematic biases that disproportionately affect historically marginalized groups underlie some of these misdiagnoses."*

It is not only people with mental illnesses who experience diagnostic overshadowing. Evidence of the negative impact of diagnostic overshadowing has been identified, for example, in patients with schizophrenia [46], people with intellectual disabilities [47], people with learning disabilities [48], with physical disabilities [49], children and young people including children with Down's Syndrome [50, 51] and with autism [52].

Cho ([45], p. 1) argues that physicians (and I would add all clinicians) *"… must pay special attention to the ways in which they or their field may be unconsciously biased towards or lack information about certain identity groups."* This is a difficult topic and one which most decidedly requires leadership, including the ability to able to influence and negotiate with all the parties involved [53].

### 3.3 Equity

One of the underpinning factors in the social epidemiology of patient safety is the equity of care. *"Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided"* ([54], p. 433). This requires that *"… equal access to available care for equal need, equal utilization for equal need, equal quality of care for* all" ([54], p. 434). I would add and equal quality and safety for all.

As noted earlier in this chapter, the Institute for Health Innovation in the USA has included equity as the quintuple aim of healthcare. This, it has been argued, requires that *"… all improvement and innovation efforts a focus on individuals and communities who need them most"* ([10], p. 521). Social work leadership can and should be involved in both identifying those individuals and communities who most need interventions and working to ensure that conscious discrimination or active bias does not occur.

The decisions around medical rationing during the COVID 19 pandemic are a case in point. Chen and McNamara ([55], p. 511) argue that *"The current public health crisis has exposed deep cracks in social equality and justice for marginalised and vulnerable communities around the world."* Lee ([56], p. 1) notes that the pandemic triggered "inequity amplifiers" including *"(1) expansion of riskscape, (2) reduction of social ties, (3) uncertainty of future, (4) losing trust in institutions, (5) coping with new knowledge,*

*and (6) straining on public spending"*. One way the 'straining on public spending' was addressed was through the issuing of treatment guidelines.

One way this played out was through the issuing of guidelines and decision tools around the world which were ageist and or ableist [57–59]. These clinical decisions tools compounded governments' often slow responses to provide the additional care required by these groups [60], even though it was clear from the start of the pandemic that they were at higher risk (as were people from certain ethnic backgrounds – both patients and staff). Discriminatory decisions ranged from the distribution of vaccines [61] to the provision of treatment and care, including *"… reported rise in the number of 'do not resuscitate' orders being imposed on people with disabilities … Vulnerable members of society, including older persons and people with disabilities, were seen as being most at risk, and healthcare professionals were advised to prioritise those who had the best chance of recovery in the event of a mass outbreak"* ([55], p. 1).

From an ethical and human rights perspective these clinical decisions, which would adversely effect some groups in the community and not others, were forms of iatrogenic harm [62]. The fact that these discriminatory guidelines emerged during a pandemic, or crisis, can provide a part explanation, but not an excuse, and they mirrored at a macro level, the decisions made at Memorial Hospital in the US during Hurricane Katrina, where patients were euthanised without their or their family's knowledge or consent [63, 64].

As Marks ([62], p. 104) argues, history *"… calls into question the very idea of the pandemic/non-pandemic distinction. Given the countless failures to heed warnings prior to COVID-19, and the inevitability of future pandemics, we must consider a pandemic as something that is either happening or about to happen. That argument becomes all the more compelling when we recognize that—as COVID-19, Hurricane Katrina, and many other crises periodically remind us—the burden of systemic failures to prepare for public health emergencies falls disproportionately on communities suffering from systemic inequalities."* In short what COVID has done is to show how deeply social attitudes towards the vulnerable can affect clinical decisions. The role of social work leadership? McGuire, Aulisio ([65], p. 23) (as part of the Association of Bioethics Program Directors (ABPD) Task Force) concluded their review of the ethical challenges arising in the COVID-19 Pandemic that *"Even in the face of the terrible burdens of an overstressed healthcare system, disability communities need special consideration to avoid inequities".*

## 4. Attributes of social work leaders addressing patient safety

I must begin this penultimate section of this chapter with the provisio that this list of attributes is neither comprehensive nor evidence based. Rather it draws on my experience and research over 30 years as an academic interested in the quality and safety of care for vulnerable groups and individuals. Competencies are often dived up into three categories: knowledge; skill and attitudes [66]. In this section I will address two key attributes for social work leaders under each of these categories.

### 4.1 Knowledge

Although there is a wide range of knowledge associated both with health leadership and with patient safety, in this section I would like to address what I believe are

two key concepts we can use as social workers engaged in improving the quality and safety of care (including all the various elements of clinical governance and similar frameworks. These are intersectionality and epistemic injustice.

### *4.1.1 Intersectionality*

As we have seen in the section on the impact of diagnostic overshadowing, it can be the multiple vulnerabilities of individuals and groups that contributed to heightened risk rather than any one single characteristic. One way of understanding that factor is through the lens of a theory called intersectionality. Intersectionality has been used to examine "*... the multiple interacting influences of social location, identity and historical oppression*" ([67], p. 288) and the way that "*... the a priori centralization of one system of inequality, social status, or identity, obscures the ways in which systems of inequality co-constitute and mutually reinforce one another*" ([68], p. 210).

This situation can be seen in the death of Mr. Brian Sinclair (although there are similar cases around the world). Mr. Sinclair "*... died in the Emergency Room [in a Canadian hospital] in 2008 ... His physician had referred him to the emergency room as he had a blocked catheter. Health care workers assumed that Sinclair was a drunk, poor, and homeless Indigenous man seeking shelter, and therefore, he was never triaged into the system. He waited 34 h[ours] in the waiting room and was pronounced dead when a physician finally decided to see him*" ([69], p. 37). In other words the assumptions made about his social status resulted in his not receiving the medical care he required.

An awareness of the intersectionality might assist in mitigating the risks faced by people such as Mr. Sinclair. Wilson, White ([70], p. 9) argue that "*Rather than pretending that differences do not exist, or minimizing their potential impact on the patient–clinician relationship, intersectionality acknowledges how multifaceted differences shape the patient–clinician interaction and forces a reframing that can lead to improved outcomes. An intersectional conceptual framework also requires an exploration of how institutional practices within the clinical environment, even those that seem neutral, unfairly advantage some and disadvantage others.*"

They conclude that "*(1) An intersectional lens requires the clinician to confront his or her own biases, whether the presumptions are of commonality or of difference between the clinician and the patient. (2) Understanding clinician–patient interaction through an intersectional lens complicates the picture, challenges assumptions (sometimes yielding surprising information), and potentially clarifies issues that arise between the patient and the clinician*" ([70], p. 13). Once again, I would argue, social workers are in a unique position to both educate other health professionals about these risk, and support the patients at risk through advocacy (which will be discussed in following sections).

### *4.1.2 Epistemic injustice*

Another source of knowledge for unpacking the social epidemiology of patient safety is through the lens of epistemic injustice [71]. "*Epistemic injustice is a kind of injustice that arises when one's capacity as an epistemic subject (eg, a knower, a reasoner) is wrongfully denied*" ([72], p. 1). There is evidence that this occurs in several ways in healthcare, including the dismissal of complaints from vulnerable groups and individuals, including people with low levels of formal education [73], people with mental illnesses [74, 75], and most recently people experiencing long COVID [76], to name just a few groups.

Understanding and addressing the risk of epistemic injustice is profoundly important for patient safety. *"Evidence provided through patient safety inquiries and a number of high profile cases includes testimonials of both patients/families and staff who have raised concerns only to have them dismissed [23]. For patients, families, carers and communities, that dismissal amounts to an epistemic injustice, where patient testimonies are "… are often dismissed as irrelevant, confused, too emotional, unhelpful, or time-con-suming' ([77], p. 530). Denial of patients' (families' and communities') concerns do the people involved a significant symbolic violence as well as actual harm [78].* As Carel and Kidd (2014, 530) note *"… ill people are more vulnerable to testimonial injustice, because they are often regarded as cognitively unreliable, emotionally compromised, or existentially unstable in ways that render their testimonies and interpretations suspect."* ([27], p. 15).

In their study of patients' access to their own case notes, Blease, Salmi [79] argue that epistemic injustice disproportionately affects what they call 'marginalised patient populations' (ie the same groups I have identified as vulnerable), *who "… may suffer a 'double injury' when it comes to information blocking. Perhaps because they are vulnerable to nonconscious forms of epistemic discrediting, and communication breakdowns, such patients may accrue greater benefits from accessing their notes away from the pressures and limitations of the face-to-face encounter"*, yet such access is less likely to occur for those groups ([79], p. 5). In other words vulnerable groups are more likely to be dis-believed (within the healthcare context) and at the same time, less likely to have access to the tools which might improve their care (such as access to their case notes). This area of knowledge ties in closely with the advocacy role for social workers, discussed under the skills section.

## 4.2 Skills

The two skills I would like to consider in relation to the role of social work leader-ship for patient safety are interprofessional practice and advocacy.

*Interprofessional practice*

Much has been written about interprofessional practice over the last two decades, and the links between poor interprofessional practice and or teamwork and unsafe care have been a recurrent theme in both large scale patient safety inquiries [23] and the research literature. As Blacker, Head ([80], p. 316) note, *"In recent years, attention to the importance of interprofessional collaboration in achieving high quality health care outcomes has been growing significantly. Such collaboration has been linked with greater provider and patient satisfaction, enhanced recruitment and retention of staff, improved patient safety and outcomes, and lower health care costs."*

Reeves, Clark ([81], p. 145) in their review of the interprofessional patient safety literature, support this argument and add that *"A common underlying reason for failures in patient safety has been ineffective teamwork and communication, which has spawned an increased emphasis on improvement … Effective interprofessional collaboration and teamwork is understood to rely on continuous and open communication, an understanding of different professional roles and responsibilities as well as respect for colleagues from dif-ferent professional groups." Blacker, Head ([80], p. 319) also note that the IHI's Triple Aim framework, which I discussed earlier in this chapter calls for "… skills in team-based care, collaboration, and interprofessional service delivery".*

Despite the evidence supporting the importance of inter-professional collabora-tion, barriers continue to hamper the practice, including professional hierarchies and leaders who are unfamiliar either with interprofessional practice per se or with the benefits thereof [80]. As Pullen-Sansfaçon and Ward ([82], p. 1284) note social

workers have a unique contribution to interprofessional practice. *"Social workers, with their values, knowledge and training in groupwork, have potentially a special role to play in facilitating interprofessional teamwork."* This is especially true if we consider Nancarrow, Booth [83] 10 principles for effective interprofessional teamwork, the first of which was for the team to identify *"... a leader who establishes a clear direction and vision for the team, while listening and providing support and supervision to the team members"* ([83], p. 5).

### 4.2.1 Advocacy

Addressing risk factors is not just matter of knowledge about the clinical evidence, but also about being understanding and address the social conditions which may contribute to people's or groups' risk, and the ability to able to advocate for those groups. As Swinford, Galucia ([84], p. 513) argued in relation to the COVID pandemic *"... social work has much to offer in our roles as researchers, educators, practitioners, and advocates during this crisis, and our foundational principles serve us well."*

Social work training is unique among health professions in preparing professionals specifically for advocacy roles. This includes providing a vision and gaining support for strategies which address health and healthcare issues through the lens of social justice [85]. As our research showed, clinicians identified patients without an advocate as being at higher risk within the health system [26], and that was before COVID shone an even brighter light on the risk of not having an advocate in healthcare [86, 87].

## 4.3 Attitudes

The final component of competency standards is that of attitudes. I have chosen two specific one to consider in relation to patient safety: compassion, which has recently emerged as focus in patient safety and humility, which is closely aligned with compassion and which ties back to questions of epistemic injustice.

### 4.3.1 Compassion

The interest in the role of compassion (as well as empathy) in organizations in general [88] and more recently in healthcare in particular [89] has gained momentum over the last decade - both in relation to healthcare staff and to patients (and their families). Dewar and Nolan ([90], p. 1249), adapted the work of Lown, Rosen [91] articulated the four essential characteristics of compassionate care: *"1) a relationship based on empathy, emotional support and efforts to understand and relieve a person's distress, suffering or concerns; 2. effective interactions between participants, over time and across settings; 3. staff, patients and families being active participants in decision making; and 4) contextualized knowledge of the patient and family both individually and as members of a network of relationships."*

Mannion [92] notes that one of the factors which might undermine compassion by healthcare providers towards patients is the compassion fatigue which is associated with caring roles associated both with high levels of stress and the high demands of emotional labour.

de Zulueta ([93], p. 1) undertook a review of the literature relating to compassionate leadership in healthcare. She argues that *"Compassionate health care is universally valued as a social and moral good to be upheld and sustained. Leadership is considered*

*pivotal for enabling the development and preservation of compassionate health care organizations."*

She goes on to describe how compassionate leadership contributes to healthcare organizations and links most of the elements identified as supporting the type of just culture required for a safe healthcare environment [94]. *"Developing leadership for compassionate care requires acknowledging and making provision for the difficulties and challenges of working in an anxiety-laden context ... This means ... sustaining high levels of trust and mutually supportive interpersonal connections, and fostering the sharing of knowledge, skills, and workload across silos. It requires enabling people to experiment without fear of reprisal, to reflect on their work, and to view errors as opportunities for learning and improvement. Tasks and relational care need to be integrated into a coherent unity, creating space for real dialog between patients, clinicians, and managers, so that together they can cocreate ways to flourish in the context of illness and dying"* ([93], p. 1).

West, Eckert ([89], p. 17) further explains this process by making explicit links between compassionate leadership and organizational cultures which provide the psychological safety for employees required to foster innovation and high-quality care. Such cultures are marked by compassionate leadership which is displayed via four key elements: "inspiring vision and strategy (i.e. unwavering focus on high-quality continually improving compassionate care; inspiring and meaningful vision; shared understanding; clear, aligned, manageable challenges and tasks; and alignment between workload and resources); positive inclusion and participation (ensuring all voices are heard; creating psychological safety and encouraging teams to be compassionate to one another; valuing diversity including patient groups, positive attitude to differences; and fair resolution of conflict); enthusiastic team and cross-boundary working (i.e. working compassionately with other teams (inter-team compassion); being supportive and collaborative; and having a 'how can we help?' attitude); and support and autonomy (i.e. creation of a positive climate – high levels of engagement, positivity and creativity; freedom to be autonomous, but with support; and treating staff with compassion).

### 4.3.2 Humility

West ([95], p. 73) also makes the link between compassion, humility and the quality of care in the following way *"Compassionate team members demonstrate a commitment to mutual support, building cohesion, modelling trust and demonstrating humility (rather than arrogance or directiveness)."* In other words, humility is strongly associated with psychological safety in teams, which in turn is associated with higher levels of patient safety [96, 97], including engagement in quality improvement work [98].

The importance of leaders' humility plays out in several ways. Firstly, as a characteristic of leaders (including of course social work leaders), humility means that the person in charge is able and willing to listen and consider the opinions of others. Humility as a leadership trait associated with effective leadership [99].

Secondly, as West ([95], p. 75) goes on to describe, humility is also a characteristic of organizations with compassionate cultures. In these organizations, *"Leadership strives to be authentic, open and honest, showing humility (a commitment to learning to improve their leadership, for example), optimism, appreciativeness and compassion."*

Thirdly, the idea of humble leadership is a *"... shift to go away from the person, hero, leader to seeing it as a process ... to get away from looking at what does the individual need to be a leader, and examining the many, many ways that leadership occurs"* ([100], n.p.) including abandoning the *"... image of the self-reliant, heroic leader in favor of a shared*

*leadership model characterized by humility and partnership*" ([101], n.p.), which in turns creates a positive organizational culture and a joint commitment to organizational goals (including patient safety and quality improvement) [102].

Finally, there is also a significant body of research which addresses the idea of cultural humility. Cultural humility as a way of addressing the needs of people from diverse backgrounds (both patients and staff) has overtaken the earlier concept of cultural competence. This is because, as Fisher-Borne, Cain ([103], p. 165) argue, "*Within social work and beyond, cultural competency has been challenged for its failure to account for the structural forces that shape individuals' experiences and opportunities. In contrast, the concept of cultural humility takes into account the fluidity of culture and challenges both individuals and institutions to address inequalities*". For social workers and all other health professionals, cultural humility "*... incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations*" ([104], p. 117).

Robinson, Masters ([105], p. 162) created what they call a conceptual model for healthcare leaders of the five 'Rs' of cultural humility, which are equal useful as a summary of the behaviors associated with leadership humility in general. The five Rs and their associated questions (which leaders ask themselves) are:

> *Reflection Aim: One will approach every encounter with humility and understanding that there is always something to learn from everyone.*
>
> *Ask: What did I learn from each person in that encounter?*
>
> *Respect Aim: One will treat every person with the utmost respect and strive to preserve dignity and respect.*
>
> *Ask: Did I treat everyone involved in that encounter respectfully?*
>
> *Regard Aim: One will hold every person in their highest regard while being aware of and not allowing unconscious biases to interfere in any interactions.*
>
> *Ask: Did unconscious biases drive this interaction?*
>
> *Relevance Aim: One will expect cultural humility to be relevant and apply this practice to every encounter.*
>
> *Ask: How was cultural humility relevant in this interaction?*
>
> *Resiliency Aim: One will embody the practice of cultural humility to enhance personal resilience and global compassion.*
>
> *Ask: How was my personal resiliency affected by this interaction?*

## 5. Conclusion

Sammer, Lykens ([106], p. 156) have identified what they call the seven subcultures of patient safety culture, *namely "(a) leadership, (b) teamwork,*

*(c) evidence-based, (d) communication, (e) learning, (f) just, and (g) patient-centered."*
In this chapter I have examined a new perspective on patient safety – that of the social epidemiology of patient safety - which addresses each of these elements. It also shows the professional strengths of social workers, and in particular on the leadership of social workers across services, systems and sectors, might help reduce harm done to patients, and in particular the most vulnerable.

## Conflict of interest

The author declares no conflict of interest.

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