

Preface

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Resilient health care (RHC) focuses on Everyday Clinical Work (ECW)—which means work as it unfolds in practice—accomplished by those working at the sharp end of the system in direct contact with patients. But ECW takes place in conditions that are significantly shaped by those at the blunt end of the system, distanced from the sharp end in both time and space. Their aim is to ensure the safety and productivity of ECW by the way they prepare, organise, and manage the conditions in which work takes place. Since today's health care takes place in complex socio-technical systems, ECW relies on workarounds, trade-offs and adjustments in order for everyday activities to succeed.

In today's health care environment, with its complicated relationships, technologies, services and practices, it is inevitable that Work-As-Done (WAD) differs from Work-As-Imagined (WAI). ECW will therefore always be different from that which is intended, planned, and prescribed. Although the differences usually are not dramatic, they may nevertheless at times lead to problems. In order to ensure that health care is resilient, it is therefore necessary continuously to realign the two perspectives on work, rather than insisting on one being right (usually WAI) and the other being wrong (usually WAD).

That is the precise point where this book hopes to make a contribution. Before we introduce the book, however, we should provide some context for both the series to which it belongs, and for the background that has brought us to our current position.

The publication of this volume completes a serendipitous trilogy of work in RHC. To understand how this happened, we need to recognise the links to ideas that existed long before the current thinking about resilience and resilience engineering (RE) began in the 1970s. These ideas, as Hollnagel suggests below in his Prologue, may even be glimpsed in Plato's stories, through Socrates' narratives, of the allegory of the cave—in which there are shadow-like appearances of people and animals on the walls of the cave (for us, WAI), and realities beyond the cave (for us, WAD). We have applied the modern version of these ideas to our enduring interest: the contemporary health system, replete with its complex idiosyncrasies, socio-professional divides, competing interests, multiplicity of treatments, care models, services, staff and subsystems, and enabling and constraining mechanisms.

RE pointed out that in the past, systems and safety experts had been preoccupied with a “find and fix” perspective, focusing on things going wrong at the expense of understanding the whole gamut of performance. To break free from that RE advocates that it is more important to understand how things work than how they fail, in order to be able to improve performance and increase the number of acceptable outcomes.

In this series of RHC books, we can also recognise a link between the three volumes. In the first volume, *Resilient Health Care* (Hollnagel, Braithwaite and Wears, 2013), we set the scene, and teased out the kinds of circumstances in which people on the front lines of care adjust, flex and accommodate in executing their functions as doctors, nurses and allied health professionals, and we glimpsed at the relative contributions of both this sharp end and the blunt end to sustaining performance. Taking a lead from work which culminated in Hollnagel (2014) the idea of two kinds of safety (Safety-I, aiming to reduce harm by trying to make sure things do not go wrong) and its reciprocal (Safety-II, aiming to improve the ability to succeed, and striving to make things go right) was teased out. The second volume, *The Resilience of Everyday Clinical Work* (Wears, Hollnagel and Braithwaite, 2015), concentrated much more directly on the front line activities, and analysed many different settings—wards, departments, emergency care, critical care, operating theatres and community pharmacies, for instance—to reveal much more than was previously understood about the activities of those making such adaptations over time.

To complete the trilogy, we need to appreciate further the relationships between those who fund the services and specify the way care should unfold, and those who deliver the services in real time. In what follows, after this Preface from the three editors and a Prologue from Hollnagel, we begin the task of deepening our understanding of these relationships and arrangements.

To do this we have divided the chapter contributions into three sections. The first, Problems and issues, covers topics as wide-ranging as what resilience is and how people can absorb the ideas it has spawned, to the patient’s role in creating resilient health care (and perhaps acting in a bridging role between WAI and WAD), to lean approaches to improvement contrasted with resilient approaches. These initial chapters establish a platform for the work that follows.

The second section, Applications, shifts the emphasis. We present here an intriguing array of contributions articulating the ways we might bring together, or at least refine our appreciation of, WAI and WAD. The chapters touch on topics including WAD and health

information technology, and the alignment of WAI and WAD in operating theatres. Other applications include how to model and represent WAD. Specific applications include manifestations of resilience in emergency care, and how systems which learn from everyday activities can contribute to narrowing the WAI-WAD nexus. Contributions also reflect on the point that power is never far away from the WAI-WAD paradigm, and, closely related to this, recognise that policymakers, managers, clinicians, patients and researchers not only have differing perspectives on RHC, but make different demands on the system which expresses it.

Armed with the information from the first and second sections readers will in the third section, Methods and Solutions, learn what to do with this information. This section distinguishes itself by advancing work contributing to bridging the gap between the WAI and WAD worlds: essentially, by researching, modelling, or simulating activities; or by purposefully designing greater levels of resilience into the care processes wherever possible in order to strengthen rather than perturb them; or to train blunt and sharp end people in the utilities and capacities of resilience thinking.

One thing remains clear. It is not possible to provide a complete description of everything that goes on in a complex workplace. In that respect, WAI inevitably falls short of the aims it has for streamlined, effective and efficient work to unfold in pre-specified ways. But neither is it possible simply to expect front line operators to get on with the job without providing them with resources, supporting systems and guidelines for performing. Both WAI and WAD are therefore essential: we simply can't have one without the other.

Our core message is that whatever our vantage point, we ought not cling stubbornly to only one view of the world and insist that it is the right one. Whether we identify mostly with a regulatory-policy, managerial, top-down, blunt end perspective, or whether our world is steeped in a front-line, practice-centric, bottom-up, sharp end perspective, having only one standpoint is both insufficient and dangerous. Care needs to be planned, managed and funded. It also needs to be rolled-out, executed and enacted. It is when plans meet reality that the two worlds meet, are able to be reconciled, and care is resilient. So it is in the synergy between the two that our hopes for better, more responsive, resilient, safer care must be based.