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Emergency departments as learning systems: a cultural complement to structural reform

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Dear Editor,

We read with great interest the article by Cipriano et al., "A decalogue for saving Italian emergency departments", published in the *Emergency Care Journal*[1]. The authors provide a timely and deliberately provocative framework for the rescue of Italian Emergency Departments (EDs), addressing the loss of mission, overcrowding, boarding, workforce depletion, medico-legal vulnerability, weak academic representation, and insufficient emergency medicine-led research.

It is important to recognise that the Decalogue already goes beyond purely economic and structural reforms. It proposes reduced working hours, optimised night work, professional diversification across the emergency care network, legal protection, mandatory research during residency, and academic chairs for emergency physicians[1]. Our purpose, therefore, is not to introduce a cultural dimension as if it were absent, but to develop a complementary operational expression of it: the transformation of the ED into a psychologically safe clinical learning system.

Clinical excellence should be institutionalised in the everyday life of the ED. Scientific production, academic recognition, and implementation research, as advocated by Cipriano et al., are essential; these ambitions must also be translated into daily team practice. Emergency care depends not only on individual knowledge but also on coordination under uncertainty, time pressure, interruptions, and competing priorities. For this reason, regular in situ simulation should become a core departmental activity. Conducted in the actual clinical environment, it allows teams to rehearse high-acuity, low-

frequency events; test protocols; improve interprofessional communication; and identify latent safety threats before they harm patients[2,3].

This educational infrastructure should be paired with structured clinical debriefing after selected complex cases, resuscitations, near misses, unexpected deaths, and major flow failures. Such debriefing should not be punitive, nor should it be confused with compulsory emotional debriefing after traumatic events. Rather, it should be a brief, facilitated, methodologically sound review of clinical performance and system conditions: what happened, what went well, what made care difficult, and what must change before the next patient[4,5]. Evidence from team-performance research indicates that debriefing can convert experience into measurable learning and improved future performance[6].

Protected educational time is therefore not a luxury. It should be formally recognised within working hours, without eroding the restorative value of the reduced workload, as proposed by the Decalogue[1]. Time for simulation, case review, guideline updating, and quality improvement should be considered part of clinical safety infrastructure, not an optional academic supplement.

The legal and institutional protection advocated by Cipriano et al.[1] must also be accompanied by internal psychological safety. Emergency physicians and nurses work in an environment where uncertainty is intrinsic and the risk of error can never be reduced to zero. In such a setting, patient safety depends on the ability of professionals to speak up, ask for help, express doubt, report near misses, and disclose mistakes without fear of humiliation or retaliation. Psychological safety, which is the shared belief that interpersonal risk-taking is permitted within a team, serves as a prerequisite for learning behaviour in complex organisations.[7] In healthcare, leader inclusiveness and flattened hierarchies have been associated with greater engagement in improvement efforts[8].

This is not a call for diminished accountability. On the contrary, psychological safety makes accountability possible because it renders problems visible while they are still correctable. A department in which clinicians hide uncertainty may appear orderly, but it is unsafe. A department in which uncertainty and failure can be intelligently discussed becomes more reliable. For this reason, ED reform should also include formal peer-support pathways after adverse events, violent episodes, unexpected deaths, and morally distressing cases. These programmes must be confidential, professionally governed, and clearly linked to escalation pathways when specialised psychological or psychiatric care is needed. The goal is not to teach clinicians to tolerate a broken system but to ensure that those exposed to the system's most extreme pressures are not left alone.

This integrated vision aligns with the Stanford Model of Professional Fulfillment, which frames physician well-being around three domains: a culture of wellness, practice efficiency, and personal resilience[9]. Its central message is crucial for emergency medicine: burnout is not primarily an

individual failure of resilience but an organisational phenomenon that requires multilevel solutions. Consistently, emergency department-specific reviews of well-being interventions suggest that strategies focused solely on individuals are unlikely to be sufficient, whereas multilevel approaches may provide more durable improvements[10].

The current exodus from emergency medicine may not be driven solely by salary, workload, or litigation but may also reflect an erosion of professional meaning. Young physicians leave when the emergency department becomes a place of sacrifice without growth, exposure without support, and responsibility without voice. Conversely, they may stay when the emergency department becomes a community of practice: demanding, but intellectually alive; stressful, but cohesive; imperfect, but committed to learning.

Cipriano et al. rightly argue that the emergency department must stop being the place where the entire healthcare system offloads what it cannot otherwise manage[1]. We would add that the emergency department must also stop being a place where professionals are expected to absorb uncertainty, violence, error, grief, and responsibility in silence. Increased hospital capacity, triage reform, legal protection, academic chairs, and better pay and working conditions are indispensable. Yet they will be insufficient unless emergency physicians and nurses are also trained, heard, supported, and allowed to learn collectively from the work they perform every day.

Only an emergency department that functions as a safety net for its professionals can remain a safety net for its patients.

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