EXECUTIVE SUMMARY

We owe it to the future not to harm our children in their hearts, and minds while we cure their diseases and repair their broken bones.

- ASSOCIATION FOR THE CARE OF CHILDREN'S HEALTH

The intent of medical care is three-fold: the maintenance of health, relief from pain, and prevention of illness and injury. The ethical responsibility to "first, do no harm" extends beyond the body and into the minds of those seeking care (Hockenberry, et al 2021). However, "Damaging the emotional being can be an unintended consequence of healing the physical being. Children and adolescents can suffer for years as a result of this paradox" (Gordon & Paisley, 2018, p. 155). Providing emotionally safe medical care ensures such harm does not befall pediatric patients and their families.

Children and adults often feel frightened, confused, and overwhelmed by medical experiences. The National Child Traumatic Stress Network reported that up to 80% of children and their families experience some traumatic stress following medical treatment for life-threatening illnesses or injuries (Effects, 2018). Iatrogenic harm is known as the disease or symptoms that are a direct, albeit unintentional, consequence of medical care. The damage is not only brought on by the treatment but also by the actions or comments of healthcare professionals (HCPs). These negative reactions can have long lasting and far-reaching consequences, greatly impacting children's physical and mental health (Landolt et al., 2009; Price et al., 2016; Zatzick et al., 2008).

Pediatric medical traumatic stress (PMTS) refers to "a set of psychological and physiological responses of children and their families to pain, injury, serious illness, medical procedures, and invasive or frightening treatment experiences" (Medical trauma, 2018, para. 1). The symptoms of PMTS include intrusive thoughts, hypervigilance, and avoidance (Kassam-Adams & Butler, 2017; Kazak, A.E., 2006; Price et al., 2016; Medical trauma 2018). Though PMTS is not a diagnosis on its own, the traumatic stress symptoms associated are part of the diagnostic criteria for both posttraumatic stress disorder and acute-stress disorder (American Psychiatric Association, 2013). These reactions are known to negatively impact children's daily functioning, adherence to medical treatment, and overall health-related quality of life (Kassam-Adams & Butler, 2017; Kazak, A.E., 2006; McCormick King et al., 2013; Price et al., 2016).

Childhood pain, anxiety, and poor coping have lifelong and costly consequences. Negative childhood experiences of medical pain and fear are significant predictors of pain, fear, and medical avoidance in adulthood (Pate et al., 1996). McMurtry et al. (2015) stated, "The emotional sequelae of unmanaged pain, most notably a fear of needles, can have a much longer lasting impact" (p. S7) and often originates from childhood experiences. Injection phobia leads to medication refusal, avoidance of preventative health, forgoing vaccinations, and delayed medical care (McMurtry

et al., 2015; Orenius et al., 2018; Wright et al., 2009). Avoiding preventative and life-saving medical care causes a significant economic burden (McMurtry et al., 2015). Just as negative medical experiences have a lasting impact, so do positive ones. Greater medical coping in adulthood is tied to positive medical coping in childhood. Similarly, when supportive measures are used for pain and fear in pediatric patients, they experience less pain and fear related to medical care as adults (Pate et al., 1996). Therefore, managing pain and providing developmentally and emotionally appropriate care in pediatrics paves the way for positive future healthcare encounters.

Pediatric healthcare professionals want what is best for their patients. However, barriers such as staffing logistics, institutional policies and practices, perceived and real time constraints, and inadequate staff training contribute to actions that may be harmful to children and families, and in turn, cause distress in medical team members. The result is that medical care delivery potentially creates lasting wounds for the patient and family, and for the HCP. Lee (2013) discussed the notion of guiding healthcare professionals to reduce suffering for patients and families, not just physically but emotionally. While experiencing distress when facing health issues is inevitable, the presence of "unnecessary anxiety" can be reduced by ameliorating the dysfunction in the delivery system (p. 1777). HCPs and the healthcare system can have a bidirectional impact on the culture of emotional safety.

The World Health Organization (n.d.) defined patient safety as the absence of preventable harm to a patient during the process of healthcare and reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. The acceptable minimum is based on collective notions derived from current knowledge and resources (World Health Organization, n.d.). To date, the level of emotional harm that pediatric patients are expected to endure is far too high. In this paper, comprehensive details are shared regarding the impact and risks associated with emotional harm to pediatric patients in the healthcare setting, and to key mitigating strategies are outlined.

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The Association of Child Life Professionals defines emotional safety (ES) as an intentional, interdisciplinary practice to promote resiliency, healing, and trust for pediatric patients and their families during medical experiences. The solution-focused practice includes proactively, comprehensively, and systematically addressing the developmental and emotional needs of pediatric patients. Emotional safety encompasses specialized strategies including atraumatic, patient and family-centered, trauma-informed, culture-centered, and developmentally appropriate care. These clinical components are woven throughout the four pillars of emotional safety: (a) screening and assessment; (b) intervention; (c) environment; and (d) education, training, and communication.. The supporting framework includes primary and sub-goals of each pillar. These key drivers were identified by researching evidenced-based practice, reviewing current best practice models, and incorporating input from content experts.

Each pillar in the emotional safety framework addresses a key area of focus. The first pillar, screening and assessment, addresses the implementation of a system that identifies patient and family perceptions, experiences, needs, and strengths. It also explores strategies for making the results accessible to all appropriate healthcare professionals, thus ensuring the implementation of interventions that prioritize, respect, and protect the emotional wellbeing of the patient and family during healthcare experiences. The second pillar, intervention, focuses on the commitment to a child's comfort and understanding regarding medical encounters. It incorporates best practices, grounded in empirical evidence whenever possible, in each patient and family encounter. The third pillar, environment, uses evidenced-based practice to promote safe and reliable environments that minimize stress and promote emotional safety for patients, families, and healthcare professionals. The fourth pillar is staff

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education, training, and communication. The goal is to facilitate collaborative relationships and to develop helpful communication strategies among the interdisciplinary team, the patient, and their support systems. The goal includes educating teams about the implementation of emotionally safe standards of care, utilizing the patient and family voice, and advocating for them within the boundaries of the medical environment. This framework is a comprehensive guide to engaging in the practice of emotional safety in pediatrics.

Wherever physical safety is discussed, emotional safety should be addressed as well. They are two sides of the same coin and both deserve equal consideration. In 2020, the Association of Child Life Professionals conducted a national survey of healthcare professionals to gauge their thoughts on emotional safety. Of the 225 HCPs who responded, 95.95% stated they believe emotional safety is equally important to physical safety. However, Sokol-Hessner et al. (2015) asserted that the awareness and prevention of emotional harm is lagging that of physical harm by over twenty years. To date, the term "patient safety" is used to reference the physical safety of the patient and rarely, if ever, considers their emotional safety. The system needs to catch up with the values held by the front-line medical professionals. As the Institute of Medicine (2000) stated, "… it is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort" (p. 3).

Healthcare professionals also suffer when emotional safety is not prioritized. Since its introduction over three decades ago, the term "moral distress" is increasingly used to describe the experience of healthcare professionals when they are routinely put into a position where they must comply with a process they believe is damaging. When they are placed in a systemic process that contradicts their belief in what is right, they can fall into a crisis (Davis et al., 2018; Garros et al., 2015; Jameton, 1984). Two examples might be assisting in medical procedures where the child's pain is not adequately controlled despite knowing there are accessible options available, or being asked to restrain a crying patient by lying them flat and holding them down during an examination when they could be held comfortably and safely by their caregivers instead. This incongruence of self leads to feelings of anger, frustration, powerlessness, and shame (Davis et al., 2018; Jameton, 1984). It can also lead to burnout (Burston & Tuckett, 2012), job dissatisfaction (Allen et al., 2013), and even to HCPs leaving the profession altogether. Rather than pathologizing moral distress in those who experience it, Tigard (2019) emphasized its value as it "…warns us of something significant being amiss and demanding systematic reform" (p. 602). The system can be changed when those within it bring to light the shortcomings and implement strategies for improvement.

It is imperative to adopt emotional safety as a core philosophy for medical delivery. Such practice will reduce patients' medical trauma and distress and foster their trust, thus paving the way for positive healthcare encounters in the future and improving their health-related quality of life. Enhancing care by systemically adopting the ES framework will also result in a decrease of moral distress experienced by healthcare professionals. The emotional safety practice, and all four pillars therein, must be incorporated into the important quality and safety work being executed by medical institutions around the world.

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EMOTIONAL SAFETY (ES) is defined as an intentional, interdisciplinary practice to promote resiliency, healing, and trust for pediatric patients and their families during medical experiences. In this paper, the term child refers to patients from birth through adolescence. Healthcare professionals (HCPs) are medical professionals who have specialized training and experience. This includes physicians, physician assistants, nurses, clinical assistants, medical technicians, specialists, and physical/occupational/speech/respiratory therapists. Psychosocial/spiritual professionals are those in the medical field who tend to the emotional, social, spiritual, and psychological needs of patients and families. They include child life specialists, clinical social workers, creative arts therapists, play therapists, chaplains, psychiatrists, and psychologists. Caregivers include the patient's parents, guardians, or adults taking primary responsibility of caring for the child. Family is used to describe whoever the child defines as their support or family. Siblings include anyone the child considers a sibling, close relative, or friend.