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A change in culture

Principles support safer care

By Steven Mulder, MD

About 25 years ago, I was practicing family medicine in rural Minnesota. I was on call for the hospital, and having a very busy day—five admissions by noon. That evening, as I was pausing to take a breath, I was paged urgently to the medical floor. One of my admissions had suffered a seizure. The RN on duty told me a glucometer reading was "less than 40." She had given the patient glucagon and the seizure had resolved after three to four minutes. Save for some brief postictal symptoms, the patient had no observable residual effects.

I reviewed the chart and discovered to my horror that I had prescribed an oral hypoglycemic agent, and the patient was not diabetic. As I sorted things out, it became clear what had happened. Two of my morning admits were elderly gentlemen of similar age and presenting complaint. One was diabetic, the other was not; I had ordered the hypoglycemic agent for the wrong patient.

As I changed the order to the correct patient, the nurse politely averted her gaze. I shared with the patient that he had had a "little spell," but that he would be fine. I did not communicate with his family. I ruefully shared my experience with a trusted colleague, whose response was, "Been there, done that!" I did not consider sharing my experience more widely; the culture of the time led me to believe that could have resulted in an uncomfortable and potentially punitive response for me and the nursing staff.

Fast-forward 22 years. I'm serving as the director of medical affairs at another rural Minnesota hospital. A patient is dealing with a frustrating, chronic problem that is defying resolution. By chance, we discover that the normal range we had calculated for a lab test was off by a factor of 10. The patient ultimately does well, but her course is affected due to this error.

The staff member who had performed the calculation was mortified. Investigation revealed the action to be simple human error within a system that was not designed to deal with the inevitability of such errors. After reviewing the event, we changed our process so that all such calculations must be independently performed by two people, confirming matching results. We met with the patient and spouse and explained what had happened and what we had done to minimize the risk of it happening again.

The two very different responses to these error events demonstrate a profound culture change—one that stresses learning and accountability over punishment and blame.

A perspective of shared responsibility

Historically, health care has been a punitive culture. Twenty-five years ago, sharing my experience so that others could learn and improve didn't occur to me. The way we addressed such incidents was to minimize or discount them as aberrations, or to discipline those involved, as a cautionary tale to others. Over time, however, we realized that that approach was resulting in the loss of invaluable learning opportunities. We then migrated to a "blame-free" culture, in which all errors were assumed to be system-based and individual accountability assumed less importance. But in fact, people do make choices about their behavior, and a level of accountability is necessary.

Enter Just Culture, a risk model for dealing with error within organizations. At Hutchinson Area Health Care, we began learning about this model of care eight years ago when we joined two other Minnesota health care organizations in a collaborative with David Marx, JD, a systems engineer who was working to translate Just Culture from the aerospace and transportation industries to health care.

Many people think this approach to safe care is simply "doing the right thing." It is that and much more. Rather than being simply a reset of where we are on the "punitive" to "blameless" continuum, this model looks at issues of risk and error from the perspective of shared accountability for patient safety and risk reduction. The organization is responsible for creating a safe system; the individual is responsible for the quality of the choices he or she makes.

System improvement is addressed through the organizational quality improvement process, such as our organization's PDSA (Plan-Do-Study-Act) model.

Individual choices are dealt with in a prescribed, rigorous process. The Just Culture "algorithm" identifies three categories of behaviors that breach the organization's policies: *Human Error, At Risk*, and *Reckless*. Response to *Human Error* behavior, unless it occurs repeatedly, is to console the employee and address system issues. *At Risk* behavior, which in some instances may be justified, generally requires additional coaching and, sometimes, remedial action. *Reckless* behavior requires discipline or termination. For example:

- Pulling a lab report from a printer and placing it on the wrong chart would be an example of a *Human Error*.
- Drawing up a parenteral pediatric medication and not double-checking it with another RN before administration, per organizational policy, would be *At Risk* behavior (potentially justified in rare instances).
- Performing an act intended to injure a patient is *Reckless* behavior.

Adopting the model

Our organizational leadership group was fairly quick to grasp these principles; looking at incidents and errors through that lens has become nearly second nature for this group. Moving those principles into our medical staff and peer review processes has been more challenging and remains a work in progress.

One challenge is that physician peer review has long suffered from outcome bias; the severity of an error and the culpability of a physician traditionally have been determined by the ultimate impact on a patient. For example, if a surgeon refuses to participate in a "time out" protocol and an error occurs but there is no adverse outcome (as will be the case at least 99.9 percent of the time), the natural tendency for the medical staff is to deal with it quite differently than if the outcome is a wrong-site surgery. Under the Just Culture model, both scenarios would constitute at-risk behavior and would be dealt with by coaching the physician and potentially disciplining him or her if there was continued noncompliance. This approach runs counter to the medical community's historical cultural and intuitive response.

If these concepts are challenging in our medical staff context, they are even more so in external environments such as the media and the law, where outcome bias is also alive and well. Malpractice allegations, especially as they are played out in the media and the courtroom, starkly reveal that the principles of Just Culture are not universally accepted. It can be difficult to hold to these principles within our organizations in the face of such outside pressures. We can do our best to try to educate these constituencies, but often we must just accept that the rules in these arenas are different and are unlikely to change any time soon.

Impact on care

Learning these principles and embedding them in our organization and medical staff has required commitment and resources, but it has been worth the effort. Now, staff and physicians more often see their work through the lens of risk awareness and reduction, rather than one of self-preservation and fear.

As the concepts of Just Culture have become more widely accepted in medicine, this organizational model is having an impact. Recently, a colleague related an experience with a patient he had referred to a tertiary center. As the patient was being prepared for discharge, the attending physician at the referral hospital called to update the referring physician on the patient's hospital course and follow-up plans. He also related that the patient's stay had been prolonged due to a medical error. As the attending was entering admission orders into the electronic health record, he had added an extra digit to an insulin order, resulting in hypoglycemia, a seizure, and transfer to the ICU. This error had been disclosed to the patient and family, as well as to my colleague, and a root cause analysis was initiated to learn how to prevent or mitigate the impact of an inevitable human error like this.

What a poignant bookend to my experience from 25 years ago! On the one hand, humans haven't changed—we still make errors. On the other hand, we've come such a long way in learning from those errors and reducing their frequency and impact. It is our responsibility to do no less.

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