Getting It Right When Things Go Wrong

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The landmark report *To Err Is Human* was a call to improve the quality of US health care. The title refers to a quote from Alexander Pope’s *An Essay on Criticism* (1711): “To err is human, to forgive divine.” The reference is convenient but not entirely appropriate, because forgiveness is inextricably linked to fault and blame. A foundation of the patient safety movement is nonjudgmental recognition of the ubiquity of human and system error. By understanding that error—particularly human error—is inevitable but preventable, patient safety efforts focus on improving systems, creating fail-safe mechanisms that intercept error before the bedside, and implementing measures that mitigate harm when an error involves the patient.

This appreciation of human imperfection created a shift from a “culture of blame” toward a “culture of safety.” The Veterans Administration summarizes this philosophy by stating that “We’ll never eliminate all individual errors. The goal is to design systems that are ‘fault tolerant,’ so that when an individual error occurs, it does not result in harm to a patient. That’s why we’ve based the Veterans Administration’s patient safety program . . . on prevention, not punishment.” This approach became known as a “no blame” patient safety model.

This “no blame” culture has been questioned with the introduction of the concept of “just culture.” The Agency for Healthcare Research and Quality describes a just culture as one that identifies and addresses systems issues that lead individuals to engage in unsafe behaviors while maintaining accountability. Marx and the Agency for Healthcare Research and Quality are careful to distinguish between “human error (eg, slips), at-risk behavior (eg, taking shortcuts), and reckless behavior (eg, ignoring required safety steps), in contrast to an overarching ‘no-blame’ approach.” However, the reemergence of accountability in health care should not focus on slips but on recklessness, which is viewed by some as tantamount to misconduct. For example, an egregious form of recklessness is willful refusal to follow widely accepted and efficacious policies, similar to a pilot refusing to use checklists or a physician consistently refusing to wash his or her hands. Such behavior unquestionably merits consequence. Perhaps the term “no blame” obfuscates the goals of the culture of safety; a shift from a culture of blame to lack of accountability was not intended. A culture of safety does not ascribe blame for errors or slips but does not tolerate recklessness or misconduct.

What should form the basis of a “just culture” in health care? When preventable error results in an adverse outcome, should the focus be on punishment or on making amends? Should anything be done if there is no harm? A similar tension is found in legal theory, which uses principles of retributive and restorative justice. Retributive justice, based on the principle of lex talionis (“an eye for an eye”), describes the culture of blame, in which fault is decreed and punishment is proportionate to harm. Restorative justice, in contrast, encourages responsibility, reparations, and rehabilitation. For example, in the retributive model, a physician who ignores “time-outs” in the operating room would lose operating privileges for 2 weeks; in the restorative model, the physician would receive advanced instruction on checklists and “never events” and be required to co-lead a training module on time-outs for new staff. Loss of privileges would remain a last resort, used only when prior remedies are ignored or ineffective. In cases of unpreventable errors or system failures, effort should not be wasted in thinking in terms of justice at all, because there is no fault per se; instead, energy should be focused on correcting the root cause of the error and outcome. In instances of at-risk behavior or recklessness, the restorative model is suggested as the primary approach, even if the patient is not harmed.

Where does the individual physician fit into a just culture that must balance no blame and accountability? While restorative disciplinary measures are appropriate in cases of misconduct involving willful disregard for safety or standards, as James Reason points out in the case of a slip, there is little benefit from simply “putting a carcass on the wall” to demonstrate that action has been taken. Setting an expectation of “never again” in the case of human error sets an unachievable goal that clinicians should not be expected to meet. After partnering with our hospital and mal-

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practice carrier to implement a multifaceted approach to improve patient safety through a program identifying and initiating specific risk-reduction clinical practices and creating a comprehensive culture of safety, 10 measures were prospectively tracked within the obstetric Adverse Outcomes Index.8 Over a 3-year period the index was reduced by more than one-third, and clinically significant improvements in safety climate were achieved as measured by validated safety-attitude surveys.8 However, while an injury-free environment remains a goal, it is clear that errors will never be completely eliminated.

Quality assurance processes that function by blaming a physician for an essential quality of their humanity, namely fallibility, fail to demonstrate empathy, a trait that is highly desired but often lacking in health care. Such blame is often misguided, because the system rather than the individual is at fault. Without losing sight of the serious consequences to the patient, adverse outcomes can also have a devastating effect on the physician, who often will have many years left to practice and thousands of patients for whom to provide care. Even before an event is reviewed, usually at the first instance of recognition, the emotional and psychological consequences to the physician begin. The sickening realization that a mistake has been made turns into dread and agony, then defensiveness and anger. In many ways the physician becomes a “second victim” and is subject to the phenomenon of secondary trauma, which occurs when one witnesses a traumatic event.9 Scott et al10 outlined the trajectory of recovery for the physician after an adverse event, noting 6 stages: (1) chaos and accident response, (2) intrusive reflections, (3) restoring personal integrity, (4) enduring the inquisition, (5) obtaining emotional first aid, and (6) moving on. The last stage encompasses 3 pathways—dropping out, surviving, or thriving.

In the wake of an error-related adverse event, great care should be taken to avoid giving the physician the sense that he or she is on trial for a crime. If not, there is the potential for losing good physicians—literally by their dropping out of practice or figuratively by their merely surviving—physicians whose only fault is being human. In evaluating a physician following an error, especially an error that causes harm, the focus should be on 3 crucial questions: (1) Was the standard of care met, including adherence to crucial policies and guidelines? (2) Is the physician willing to incorporate lessons learned into future practice? and (3) Is the physician committed to maintaining his or her relationship with the patient and participating in a full disclosure of events?

At all times, but particularly when answers to these questions are yes, physicians deserve maximal support. It is especially powerful if the physician can maintain a role as an advocate for the patient’s best interests throughout the process, including deliberations regarding potential compensation. A restorative approach, in both the legal and traditional sense of restoration, may indeed be the key to getting it right when things go wrong.

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REFERENCES