Manage Risk, Build a Just Culture

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Catholic health care organizations have a rich and robust moral tradition that permeates all that they do. The contemporary risk-management model called the "just culture" is a perfect fit for Catholic health care because it has strong parallels in the Catholic moral tradition.

The concept of a fair and just culture refers to the way an organization handles safety issues. Humans are fallible; they make mistakes. In a just culture, "hazardous" human behavior such as staff errors, near-misses and risky actions are identified and discussed openly in hopes of finding ways to improve processes and systems — not to identify and punish the individual.

Since 1997, David Marx and his risk management firm, Outcome Engineering LLC, have pioneered the concept of the just culture.[1] They and others have contributed to an important body of literature on just approaches to human error and accountability in the pursuit of safety.[2]

The just culture model has been gaining acceptance in such high-risk industries as health care, nuclear power, aerospace and aviation. Some Catholic health care institutions have implemented the model, as well, but it isn't universally used.[3] In this article we outline some of the parallels between the just culture model and the Catholic moral tradition and show that Catholic health care presents fertile ground for the approach.

HUMAN FALLIBILITY AND IMPERFECTION

If we align the just culture model and the Catholic moral tradition, we recognize that one of health care's moral imperatives should not be to create perfect doctors and nurses.[4] Rather, the moral imperative is to deliver the safest health care by taking account of human fallibility and the imperfection of systems. This is the only way we can expose our vulnerabilities and learn the truth about our actions and systems so as to improve health care.

Catholic health care is, in fact, good medical care. As such, it requires caregivers to make good choices — safe choices. It is the quality of one's choices that forms the basis of a just culture, not exclusive attention to outcomes. Similarly, in the Catholic moral tradition, the assessment of human conduct does not begin with and is not defined by the outcomes or consequences of actions. Outcomes do have a place in the evaluation of an act's status, but they are not decisive. The moral value or status of a human act is determined on the basis of three integral components: the act's moral object or nature; its intention; and the circumstances associated with the act.[5]

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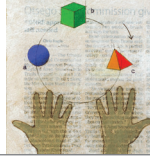

As in the Catholic moral tradition, what someone does, together with the intention and circumstances of the action, are the focus of risk management in the just culture. In 2000, the Institute of Medicine released *To Err Is Human*, which contends that medical errors are not the result of "bad apples" in the health care field, but that good people are working in flawed systems and these systems need to be re-engineered to be made safer.[6]

When we try to treat human beings like perfect machines, we will always be disappointed by variability and unexpected failures. Here's the truth: We may be able to reduce human cognitive errors, but we will never be able to eliminate them.

While there are great efforts in the medical community to pursue perfection with evidence-based, data-driven performance improvement, these efforts are continually hampered by our flawed idea that humans are expected to be perfect. But as Marx points out, human action, with its fallibilities, is more like the spinning of a roulette wheel.[7]

The just culture model is built on the premise that the assessment of risk-taking ought not to go beyond what can be reasonably expected from fallible human beings and the subject matter at hand. The Catholic moral tradition also holds that these are central elements in the understanding of human action. This important parallel is evident, for example, in the adaptation of Aristotle's insight that we ought not to expect any more precision in human knowledge than what a subject-matter allows; in the work of Saint Thomas Aquinas on voluntary and involuntary action and the foreseeing of the consequences of action; and in the work of Blessed John Henry Newman on reasoning in concrete matters.[8]

KEY DISTINCTIONS

Though fallibility is something that we must accept, how do we manage it? In our current punitive culture — and the medical industry is no exception — we blame people largely based on outcomes rather on than their actions. Our response to errors and to mistakes that end badly is to spew out more policies, disciplinary measures, warnings, naming and blaming. Mistakes that don't cause repercussions somehow tend to escape moral and ethical labels.

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For example, a surgeon rips a glove during an operation and the assisting nurse points it out, admonishing the surgeon to put on a sterile glove. The surgeon declines. If the patient winds up with a life-threatening infection, the surgeon's irresponsible and reckless behavior may result in a lawsuit and perhaps loss of hospital privileges and medical license. Yet if the patient's recovery is uneventful, the surgeon isn't likely to be punished for his choice.

The just culture model distinguishes among human error, at-risk behavior, reckless behavior, malicious willful violations and the corresponding levels of accountability.

A mistake or error is not necessarily a choice.[9] If a doctor writing a prescription doesn't know the medication contains an obscure ingredient to which his patient happens to be allergic, the doctor hasn't chosen an action that caused an allergic reaction. He has made a mistake, and the just culture response is one of consoling, educating, emphasizing situational awareness and/or handing out remedial work — but not punishment. In fact, mistakes should trigger a look at the overall system to see if there are ways to prevent such errors from passing through and reaching patients.[10]

A nurse chooses to save valuable time by not checking a patient's identification wrist band per

Type of action	Mistakes, lapses, errors	At-risk behavior (mild to severe)	Reckless behavior	Malicious behavior	Malicious/criminal behavior
State of knowledge	Antecedent ignorance	Consequent ignorance		Concomitant ignorance	With knowledge and intention
Foresight of outcomes	Reasonably unforeseen	Outcomes may have been reasonably unforeseen in some cases but should have been foreseen in others			Clearly foreseen

hospital policy before administering a medication. Even if there is no adverse result, the choice puts the patient at an increased risk. The nurse who violated the wrist-band rule either didn't recognize the action as a violation, or mistakenly believed it to be justified — but the nurse's action was no mistake. It was an intentional choice that would be considered an at-risk behavior, whatever the outcome. The just culture's response to at-risk behaviors involves coaching, incentives, disincentives and sometimes firm counseling. The focus is on the behavior, not on the individual, and there would be an investigation to determine why that kind of conduct takes place and how prevalent it is.

Reckless behavior is action that carries substantial and unjustifiable risk for an adverse event. The person who acts recklessly fully recognizes the risk, but does not actually intend the adverse consequence. Examples of reckless behavior are driving drunk and the surgeon who knowingly operated with a ripped glove.

Malicious willful acts intend harm. They are acts (or omissions) in which the person fully knows or foresees the result but proceeds in spite of it. The clinician who knowingly causes a patient needless suffering by diverting her pain pills in order to sell them is behaving maliciously, not recklessly.

Whatever their outcome, reckless behavior and malicious willful acts call for punishment due to conscious disregard of an unjustifiable, well-known medical risk. Punishment is a punitive deterrent of a behavioral choice. It usually involves a loss, such as a loss of privileges, license, job, status, rank, money and freedom (jail).[11]

PARALLELS WITH CATHOLIC MORAL TRADITION

The just culture model shares additional parallels with the Catholic moral tradition in respect to the voluntariness of human action.[12] Human error is similar to what is known as antecedent ignorance in the Catholic moral tradition. This type of ignorance both precedes the act of the will and causes the action, because the person would have acted differently had he or she known all the circumstances. This ignorance is categorized as morally invincible because it could not have been reasonably overcome and the person is therefore not obligated to know the circumstances.

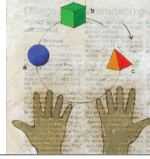
At-risk behavior is parallel to consequent ignorance in the Catholic moral tradition. In the case of an adverse event, a person who pleads ignorance as an excuse for not knowing laws or rules that she or he is obligated to know is showing consequent ignorance. This ignorance is willed. Another type of consequent ignorance is due to a person's inattention or carelessness in making an effort to acquire the knowledge he or she should possess for an action. The person is responsible for his or her lack of relevant knowledge, and this makes the action voluntary to varying degrees, depending upon the extent to which the ignorance is willful. Just as consequent ignorance in the Catholic moral tradition covers a range of willful ignorance, so too is there a range of at-risk behaviors, from mild to severe, in the just culture.

Consequent ignorance straddles both at-risk and reckless behaviors. The drunk driver knows that becoming drunk before driving will prevent him from operating a vehicle in a way that would help him avoid a harmful event. This direct willingness to ignore the way alcohol impairs his driving ability is consistent with the notion of consequent ignorance.

Both the just culture and the culture of Catholic health care are about "doing the right thing" in the treatment of caregivers.

Reckless behavior also parallels what is known in the Catholic moral tradition as concomitant ignorance. Concomitant ignorance is consistent with the real will of the person. The person may not have known at the time that an act would have an adverse consequence, but even if the person did know, he or she has no regret and would have done the same anyway. Concomitant ignorance and reckless behavior share a clear willingness to take substantial and unjustifiable risks. A nurse, for example, may unknowingly give the wrong medication and cause a very sick patient's death. Later, she might rejoice in her action because she believes that the suffering of dying patients should be ended with lethal medications.

The ability to foresee the consequences of an action factors into an act's moral evaluation. Both in the Catholic moral tradition and in the just culture model, a person's responsibility for an action's unforeseen consequences depends on how those effects relate to the action.[13] Unforeseen consequences that cannot be reasonably anticipated parallel the concept of human error and mistakes. However the person who engages



in at-risk behavior is expected to know what the unforeseen consequences could be, given how those consequences are normally related to the action. Acting despite reasonably foreseeable, numerous or substantial adverse consequences is parallel to reckless behavior.

NATURAL LAW, SAFETY AND A LEARNING CULTURE

Commenting on the logic that underlies society's laws and rules, Marx correctly observes, "It is about doing the right thing. Somewhere along the way, we transitioned into a society that says, 'Do what you want . . . as long as you don't hurt anyone.'"[14] In this view of human action, the duty to produce an outcome is the only significant measure. It is the predominant view in our culture.

The goal is not blame but rather process improvement, ultimately to advance patient safety.

In the just culture model, this duty must strike a balance with two others — the "duty to follow a procedural rule" and the "duty not to cause unjustifiable harm" — but the duty to not cause unjustifiable risk transcends the others.[15] Both the Catholic moral tradition and the just culture model recognize this duty as a norm of the natural moral law.[16] It is the duty to preserve human life and is in part fulfilled by not taking unjustifiable risk either for oneself or others. Moreover, for both the Catholic moral tradition and the just culture model, it is a duty closely related to another natural law obligation: to live justly in society.

A well-designed system of delivering health care is one that promotes shared accountability and embraces the multifaceted relationships of consoling human error, coaching at-risk behavior and punishing reckless and malicious behavior. Such a system necessarily promotes a learning culture in which all participants are motivated to be truthful about mistakes and at-risk behavior, therefore allowing improvements to the system so that the duty to avoid causing unjustifiable risk is better fulfilled.

It is important to note that in a learning culture, we learn not from mistakes as such, but from truth. Mistakes and ignorance presuppose truth, and the organization that doesn't promote a truth-seeking culture drives potential learning underground.

Learning as the acquisition of knowledge about reality comes not from a lack of truth (ignorance, mistakes) but from what is known to be true. Mistakes are the occasion for learning the truth of what we previously did not adequately know or fully accept.

This view of learning is also consistent with the Catholic moral tradition, which views the human person as being created to know truth and freely act. Pursuing truth is central to freedom of action and to the moral evaluation of action in the Catholic moral tradition, according to which freedom is fulfilled through the realization of the truth about human dignity.

An organization that incorporates a just culture is designed for truthfulness and is one that is committed to the proper balance of truth and freedom in the assessment of risk and in the design of safe systems.

A learning environment should be an essential part of a health care organization's strategy for survival and growth. The goal is not blame but rather process improvement, ultimately to advance patient safety. In order for an organization to learn, it is important to realize that human error can be mitigated but never eliminated. Punitive action is reserved for the relatively uncommon reckless behaviors and the rare outright malicious, willful violations. In most punitive cultures, one only feels safe to report about equipment malfunctions. As the learning, just culture grows in an organization, one feels safe to report on other people accurately, then report one's own mistakes, and lastly report one's own violations in policy.[17]

THE CULTURE OF CATHOLIC HEALTH CARE

So why should health care, and Catholic health care in particular, adopt a just culture? The only fair option is to recognize that individuals are fallible human beings who work within imperfect systems. Thus, it is important to identify mistakes and near misses openly so that we can learn from the truth and redesign systems to engineer out the fallible human element as much as possible. If risk management is to be truly effective, it must hinge on establishing a "reporting culture." Performance improvement professionals have a mantra: We cannot improve what we cannot measure. Just culture proponents offer the principle that we cannot measure what we cannot identify. We can only identify mistakes and near-misses when we feel safe to do so without the risk of unjustified punishment. If we cannot identify these mistakes and near-misses, then we cannot evaluate and learn the truth.

Both the just culture and the culture of Catho-

lic health care are about "doing the right thing" in the treatment of caregivers. The culture of Catholic health care is characterized by, among other things, absolute respect for human dignity, respect for the nature of human action, mutual respect among caregivers, justice and fidelity to the Catholic moral tradition. All of these factors coalesce to provide Catholic health care with a solid moral foundation for the implementation of the just culture model. This congruency between the Catholic moral tradition and the just culture model means that the culture of Catholic health care everywhere ought to be a just culture.

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NOTES

1. See, for example, David Marx, *Whack-a-Mole: The Price We Pay for Expecting Perfection* (Plano, Texas: By Your Side Studios, 2009); David Marx, *Patient Safety and the "Just Culture": A Primer for Health Care Executives* (New York, NY: Columbia University, 2001) http://www.psnet.ahrq.gov/resource.aspx?resourceID=1582.
2. James Reason, *Human Error* (Cambridge: Cambridge University Press, 1990); James Reason, *Managing the Risks of Organizational Accidents*, First edition (Hampshire, England: Ashgate Publishing, 1997); James Reason, *The Human Contribution: Unsafe Acts, Accidents and Heroic Recoveries* (Burlington, Vt.: Ashgate Publishing, 2008); Sidney Dekker, *Just Culture: Balancing Safety and Accountability* (Burlington, Vt.: Ashgate Publishing, 2007); Sidney Dekker, et al., *Behind Human Error*, Second Edition (Burlington, Vt.: Ashgate Publishing, 2010).
3. Jeffrey S. Rose et al., "A Leadership Framework for Culture Change," *Health Care, Journal on Quality and Patient Safety* 32, no. 8 (August 2006): 433-442; Lynette Ballard, "Putting Safety at the Core," *Health Progress*, January-February 2006: 29-34; Paul Conlon and Gale Gartner, "A Jury of Our PEERS," *Health Progress*, January-February 2006: 39-42.
4. Lucian Leape, "Error in Medicine," *Journal of the American Medical Association*, 272, no. 23 (1994): 1851-1857; Jerome Groopman, *How Doctors Think* (Boston: Houghton Mifflin Company, 2007); Atul Gawande, *Better: A Surgeon's Notes on Performance* (New York, NY: Picador, 2008).
5. *Catechism of the Catholic Church*, Second Edition (Vatican City: Liberia Editrice Vaticana): ns. 1750-1756.
6. See Institute of Medicine, *To Err Is Human: Building a Safer Health System*, First edition (Washington, D.C.: National Academies Press, 2000); W. Edwards Deming, *Out of the Crisis* (Boston: MIT Press, 2000); Institute for Healthcare Improvement, "Improvement Tip: Want a New Level of Performance? Get a New System" www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/ImprovementStories/ImprovementTipWantaNewLevelofPerformanceGetaNewSystem.htm.
7. Marx, *Whack-a-Mole*, 17.
8. Aristotle, *Nicomachean Ethics*, W.D. Ross, trans. in *The Basic Works of Aristotle*, Richard McKeon, ed. (New York: Random House, 1941); St. Thomas Aquinas, *Commentary on the Nicomachean Ethics*, C.I. Litzinger, OP, trans. (Notre Dame, Ind.: Dumb Ox Books, 1993); John Henry Newman, *A Grammar of Assent*, (Notre Dame, Ind.: University of Notre Dame Press, 1979).
9. Marx, Whack-a-Mole, 48.
10. Reason, *Managing the Risks of Organizational Accidents*.
11. Marx, *Whack-a-Mole*, 42.
12. St. Thomas Aquinas, *Summa Theologiae* I-II, q. 76; De Malo, q. 3, a. 8.
13. St. Thomas Aquinas, *Summa Theologiae* I-II, q. 20, a. 5, and *Summa contra Gentiles*, III, ch. 6, notes. 4 and 7.
14. Marx, *Whack-a-Mole*, 99.
15. Marx, *Whack-a-Mole*, 77-82.
16. Marx, *Whack-a-Mole*, 81-82; 96; see also St. Thomas Aquinas, *Summa Theologiae* I-II, q. 94, a. 2; *Catechism of the Catholic Church*, 1950-1960.
17. Reason, *Managing the Risks of Organizational Accidents*, 218; R.I. Sutton, "Organizing for High Reliability: Processes of Collective Mindfulness" in *Research in Organizational Behavior*, Vol. 21. First edition (Albany: Jai Press, 1999. 23-81); Marx, *Whack-a-Mole*, 116.

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