

Walking the Punitive/Blame-Free Tightrope

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Before 1990, health care was a highly punitive field. When mistakes were made, they were the fault of the individual. Fear of retribution caused mistakes to go unreported, and the opportunity to expand our knowledge about errors was lost.

In medicine, the consequences of human error can be severe. But often, the problem is bigger than the person. In situations where nine out of 10 people would have made the same mistake, punishment does not make sense.

By the mid-'90s, there was a shift in health care from punitive to blame-free, but it too had shortcomings. Blame-free cultures removed all fault from the individual and emphasized momentary lapses in judgment or problems with the larger system as a whole. While this new culture made it more acceptable to report errors, errors that were caused by truly reckless individuals went unpunished.

Now emerges the Just Culture model, which strikes a balance between a need for a non-punitive learning environment and accountability. Just Culture emphasizes that the problem is seldom the fault of an individual but, instead, the fault of the system or process. Changing the people without addressing the system or process issues will not solve the problem. At the same time, it recognizes the need for accountability — both for the system of care and for genuinely reckless acts.

The Institute of Medicine's 1999 *To Err Is Human: Building a Safer Health System* pro-

jected that between 44,000 and 98,000 Americans die each year in hospitals as a result of preventable medical errors. Investigation of these preventable errors has repeatedly demonstrated that "good staff" plus bad systemic processes lead to adverse patient events. Even the most careful individual makes mistakes. After all, we are human.

Discovering the true extent of medical errors requires an environment that encourages individuals to report medical errors — those that they commit and those that others commit. Reporting of errors provides key information about why errors happen and how to prevent them.

In Missouri, currently, there is no mechanism in place to capture the extent of medical errors. The Missouri Center for Patient Safety, a non-profit organization dedicated to promoting safe and quality health care through reduction of medical errors, hopes to change that. By establishing a voluntary, confidential reporting system that is consistent with national patient-safety organization legislation, criteria and requirements, Missouri will be able to identify patient-safety concerns, share best practices and establish a focus for improvement activities.

The Missouri Center for Patient Safety and other state health care leaders have recently undertaken the Just Culture Collaborative. The project, launched in September 2007, was made possible by a grant from the National Council of State Nursing Boards and aims to

establish a common understanding of why medical errors happen and improve methods for preventing them. More than 65 teams have enrolled in the Just Culture Collaborative, including hospitals, nursing homes, home health agencies, physician clinics, state regulatory agencies, statewide associations and a health care professional school. While many health systems have implemented a Just Culture model in their facilities, this is the first project to apply Just Culture principles broadly throughout the state.

A learning culture, such as that facilitated by the Just Culture Collaborative, is the foundation of patient safety. In order to create this learning system, organizations must move away from the overly punitive culture. But a learning environment does not remove all blame. Truly reckless people must be held accountable for their actions. All health care providers must be accountable for safety, from the Board to the management team all the way to front-line staff.

The Just Culture focuses on improving patient safety by designing capable systems around the health care provider and relying on them to make safe choices within those systems. By doing this, each individual is given the tools he/she needs to succeed. Although errors may never be eliminated, appropriately addressing those errors that do occur is paramount to reduce the risk to your patients.