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HEALTH LAW

Why Accountability Sharing in Health Care Organizational Cultures Means Patients Are Probably Safer

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Abstract

Because human errors should be regarded as expected events, health care organizations should routinize processes aimed at human error prevention, limit negative consequences when human errors do occur, and support and educate those who have erred. A just culture perspective suggests that responding punitively to those who err should be reserved for those who have willfully and irremediably caused harm, because punishment creates blame-based workplace cultures that deter error reporting, which makes patients less safe.

A Case of One Kind of Medication Error

Despite their best conscientious efforts, physicians and other health care clinicians will inevitably make mistakes by omission, commission, or simply as a result of human nature and imperfections of work environments. A recent case from Tennessee highlights an example of medication error and can serve as the basis of an analysis of accountability in health care. The facts of the case are as follows: due to claustrophobia, an elderly patient who was anxious about a scheduled positron emission tomography (PET) scan was prescribed midazolam hydrochloride to help her feel more at ease.[1] This patient's nurse proceeded to retrieve the drug from an automatic dispensing cabinet. The dispenser's override feature enabled the nurse to select the first drug result displayed,[1] dismiss a series of 5 pop-up warnings, and withdraw the selected (wrong) drug—a paralyzing agent—from the cabinet.[2] The nurse removed a vial labeled with a paralysis warning from the cabinet dispenser, delivered it to the radiology department where the patient's PET scan was about to occur, and administered the drug to the patient via injection as directed. Thirty minutes later, the patient was found in cardiac arrest. Although the patient was resuscitated and transferred to an intensive care unit, clinicians deemed the patient unlikely to recover and the patient's family agreed another resuscitation attempt would not be appropriate. The patient was extubated and died shortly thereafter.[1]

Codes and Cultures

When analyzing this case of medication error, 2 organizations' codes of ethics can be drawn on to illuminate key features of organizational cultures in health care that inform what might be an appropriate response. For example, *The Code of Ethics for Nurses*

states: "[W]hile ensuring that nurses are held accountable for individual practice, errors should be corrected or remediated, and disciplinary action taken only if warranted."[3] Responding punitively to nurses who err, such as terminating their employment or charging them criminally, might not be warranted because the American Nurses Association believes that "[C]riminalization of medical errors could have a chilling effect on reporting and process improvement."[4]

The American Medical Association's *Code of Medical Ethics* Opinion 8.6, "Promoting Patient Safety," emphasizes both individual and collective accountability for errors. Physicians, who are "uniquely positioned to have a comprehensive view of the care patients receive," should "strive to ensure patient safety" and additionally "play a central role in identifying, reducing, and preventing medical errors."[5] Opinion 8.6 further states: "Both as individuals and collectively as a profession, physicians should support a positive culture of patient safety, including compassion for peers who have been involved in a medical error."[5]

Each of these organizations' code statements underscores the importance of viewing any clinician action, including an error, in light of the social and cultural context in which that action was carried out.

Just Culture

Just culture offers a model for creating positive workplaces in health care settings[6,7] by balancing "the need for an open and honest reporting environment with the end of a quality learning environment and culture."[7] Its premises echo conclusions from the Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System*,[8] which found that most medical errors arise from "faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them" rather than from reckless actions by individuals working within those systems.[9] As a result, the just culture model serves as a guide for health care systems and institutions by incorporating elements such as human factor design, error prevention, and steps to contain errors' consequences before they become critical. Its goals are to create a fair and open environment to promote learning, support the design and implementation of safety systems, and guide behavioral choices.

Although a just culture framework views adverse outcome events as opportunities to understand any contributing risks and how to mitigate them, it is not blame free. A just culture framework endeavors to balance 3 basic duties—to avoid causing unjustified risk or harm, to produce desired outcomes, and to follow procedural rules—against shared organizational and individual values of dignity, safety, equity, cost, and effectiveness.[6,7] Under the just culture framework, medical mistakes, such as medication errors, can be classified as simple human error (eg, unintentional errors or lapses), as risky behaviors (ie, "a conscious drift" toward actions in which the risks taken are unforeseen or mistakenly believed to be justified), or as recklessness, defined as willful disregard of unjustified risks.[7] Recommended remedies for these mistakes are, respectively, consolation, coaching to understand risks, and punishment, where corrective responses are based upon clinician behaviors rather than patient outcomes.[7]

Cultures Compared

Just culture and law enforcement both aim to prevent harm to persons or patients, property, and public interests. Just culture emphasizes the quality or desirability of an individual's choices and behaviors and apportions corrective actions or discipline on

that basis more so than on the severity of the consequences. Criminal law, on the other hand, often focuses on outcomes, and while the law "generally disallow[s] criminal punishment for careless conduct, absent proof of gross negligence" (ie, a heightened level of negligence that may include recklessness), some "legislatures occasionally permit punishment based on ordinary negligence, primarily when the conduct is extremely dangerous and may cause harm to a significant number of people."[10] Just culture also attempts to differentiate degrees of intent or blame more finely than the law does. These gradations range from ordinary human error at the low end of culpability, to risky behaviors, recklessness, and, finally, purposeful action to inflict harm.[7,11] Criminal law often creates a "twilight zone" in its vague interpretation of the various degrees of negligence, ie, "willful," "wanton," "reckless," and "gross" negligence, which may encompass "recklessness."[12] In a just culture model, negligence encompasses both unintentional errors (accidents) and risky behavior (decisions) but not recklessness.[11] Instead of imposing punishments for all categories of failures of duty, just culture advocates acceptance and support for errors, coaching to change risky behaviors, and discipline or punishment for those whose actions are reckless because they were committed with knowledge of harm or with purposeful intent to harm.[7]

Returning to the case example of medication error, those espousing a just culture perspective might observe that the nurse chose to override orders and warnings from the drug cabinet and that she neglected to confirm the drug, record the injection, and monitor the patient. However, the patient's death, though tragic, was unintended. Although the nurse's mistakes may have been numerous, they began with a human error of selecting the wrong medication. As a result, the nurse's culpability could be construed as being low (simple error or risky behavior), and the corresponding remedies would be support and education rather than criminal prosecution. In this vein, some might argue that her choices and her awareness of risk, not the outcome, should be the crucial determinants of the correct response. She would not be considered reckless if she was not cognizant of risks. Her attention might have been drawn elsewhere—to her trainee, for example.

Or, she might have been enculturated into daily workplace practices of using the override functions without fully appreciating the potential hazards, reflecting the human tendency to drift away from stringent adherence to standards. Just culture would consider this behavior risky but natural.[10] David Marx describes this "propensity to drift into at-risk behaviors" using an automotive example in which one driver is driving 9 miles per hour over the speed limit, while another driver may be driving 50 miles per hour over the speed limit and swerving wildly. The first driver is "drifting," not consciously aware of the risk, whereas the second driver is clearly driving with conscience knowledge of his or her recklessness.[10] Because the just culture model views "the propensity to drift" as "part of our human nature," mitigating at-risk behavior caused by "drifting" should be the focus in designing hospital patient safety programs.[10] Under a just culture model, punishment of the nurse in this case would erode confidence and trust among coworkers and institutions and deter open disclosure and discussion of mistakes made.

By contrast, those adopting a "finger pointing" stance (eg, one that might arise under criminal law) might argue that the nurse's actions were indeed criminally reckless rather than merely erroneous. Her actions could be akin to those of a driver who is texting or speeding and strikes a passerby, killing him or her; both the driver's and the nurse's

actions were choices rather than mere errors, and the consequences were foreseeable and preventable.

Conclusion

The goal of minimizing mistakes, including human errors, is aided by culture and organizations that foster communication and education and punish only when warranted. A just culture model proposes that individuals working within a system should not be held responsible for mistakes or choices they make if that system fails to prevent foreseeable errors; rather, health systems and institutions should positively guide anticipated interactions and actively participate in monitoring, reporting, and fixing shortcomings to improve patient safety.

References

1. Centers for Medicare and Medicaid Services, US Department of Health and Human Services. Statement of deficiencies and plan of correction: Vanderbilt University Medical Center. IOMB 0938-0391. https://hospitalwatchdog.org/wp-content/uploads/VANDERBILT-CMS-PDF.pdf. Published November 19, 2018. Accessed July 17, 2020.
2. Shelton C. Investigation: former Vandy nurse admits she "f----d" up, multiple overrides lead to death. *Fox 17 Nashville*. March 27, 2019. https://fox17.com/news/local/investigation-former-vandy-nurse-admits-she-f-d-up-multiple-overrides-lead-to-death. Accessed July 9, 2020.
3. American Nurses Association. Code of ethics for nurses with interpretive statements. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/. Published 2015. Accessed July 17, 2020.
4. ANA responds to Vanderbilt nurse incident [press release]. Silver Spring, MD: American Nurses Association; February 19, 2019. https://www.nursingworld.org/news/news-releases/2019-news-releases/ana-responds-to-vanderbilt-nurse-incident/. Published February 19, 2019. Accessed July 9, 2020.
5. American Medical Association. Opinion 8.6 Promoting patient safety. *Code of Medical Ethics*. https://www.ama-assn.org/delivering-care/ethics/promoting-patient-safety. Published November 14, 2016. Accessed July 9, 2020.
6. Marx D. Patient safety and the "just culture." Just Culture Community. https://www.unmc.edu/patient-safety/_documents/patient-safety-and-the-just-culture.pdf. Published 2007. Accessed July 9, 2020.
7. Boysen PG II. Just culture: a foundation for balanced accountability and patient safety. *Oschsner J.* 2013;13(3):400-406.
8. Kohn LT, Corrigan JM, Donaldson MS, eds; Committee on Quality of Health Care in America, Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 2000.
9. Institute of Medicine. Report brief: *To Err is Human: Building a Safer Health System*. https://www.nap.edu/resource/9728/To-Err-is-Human-1999--report-brief.pdf. Published November 1999.
10. Garfield LY. A more principled approach to criminalizing negligence: a prescription for the legislature. *Tenn Law Rev.* 1998;65(4);875-924.
11. Marx D. Reckless homicide at Vanderbilt? A just culture analysis. Outcome Engenuity. https://www.outcome-eng.com/wp-content/uploads/2019/03/Vanderbilt-Homicide-A-Just-Culture-Analysis_David-Marx.pdf. Published March 2019. Accessed July 9, 2020.

12. Byrd EH. Reflections on willful, wanton, reckless, and gross negligence. *LA Law Rev*. 1987;48(6):1383-1410.

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