



Medical Event Reporting System for Transfusion Medicine

# Patient Safety and the "Just Culture": A Primer for Health Care Executives

April 17, 2001

Prepared by David Marx, JD  
David Marx Consulting

in support of Columbia University

Funded by a grant from the National Heart, Lung, and Blood Institute  
National Institutes of Health  
(Grant RO1 HL53772, Harold S. Kaplan, MD, Principal Investigator)

Copyright © 2001  
by the Trustees of Columbia University in the City of New York  
All Rights Reserved

May be reproduced in whole or in part for noncommercial use provided  
that the following appears on the first page of the reproduction:  
"Prepared by David Marx, JD, for Columbia University under a grant  
provided by the National Heart, Lung, and Blood Institute "

**Patient Safety and the “Just Culture:” A Primer For Health Care Executives  
Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

---

I.	Executive Summary .....	3
II.	The Problem Statement .....	4
III.	An Introduction to Disciplinary System Theory .....	5
A.	The Four Evils .....	5
1.	Human Error .....	6
2.	Negligent Conduct .....	6
3.	Reckless Conduct.....	7
4.	Intentional Rule Violations.....	7
B.	Application to Transfusion Scenarios .....	7
1.	Scenario 1- The Memory Error.....	7
2.	Scenario 2 – The Misplaced Tube .....	9
3.	Scenario 3 – The Reckless Technologist .....	11
C.	Disciplinary Decision-Making Strategies .....	13
1.	Outcome-Based Disciplinary Decision-Making.....	13
2.	Rule-Based Disciplinary Decision-Making .....	14
3.	Risk-Based Disciplinary Decision-Making .....	16
D.	Distinguishing Compensatory and Punitive Goals.....	18
IV.	Where We Stand Today .....	19
A.	The Regulatory Perspective .....	19
B.	The Corporate Perspective .....	20
C.	A Note on Repetitive Errors.....	23
D.	A Note on Qualification .....	24
V.	Your Task as a Health Care Executive.....	25
VI.	Conclusion .....	27

## **Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

---

### **I. Executive Summary**

As part of the ongoing effort to improve transfusion safety, MERS-TM provides a standardized means of organized data collection and analysis of transfusion errors, adverse events, and near misses. Its effectiveness depends on the willingness of individuals to report such information. This report is designed as an aid for health care executives, labor attorneys, labor leaders, and human resource specialists who must struggle with what to do, in the disciplinary context, with an erring health care professional. It is a guide for more thoroughly understanding the problems posed by current disciplinary approaches, and to possible changes in your current disciplinary policies as you contemplate implementation of a new reporting and investigation system.

Today, most corporate disciplinary systems literally prohibit human error. That is, mere human error, when coupled with harm to a patient, will raise the specter of social condemnation and disciplinary action. Advances in patient safety, especially when involving the management of human error, depend upon our collective ability to learn from our mistakes – whether they are near misses or mistakes resulting in actual harm to a patient. To promote a culture in which we learn from our mistakes, organizations must re-evaluate just how their disciplinary system fits into the equation. Disciplining employees in response to honest mistakes does little to improve overall system safety. Yet, mishaps accompanied by intoxication or malicious behavior presents an obvious and valid objection to today’s call for blame-free error reporting systems.

It is through the lessons of our everyday errors that we can design our work environment to be less error prone and more error tolerant. Few people are willing to come forward and admit to an error when they face the full force of their corporate disciplinary policy, a regulatory enforcement scheme, or our onerous tort liability system. To collect productive investigative data, we must promote a culture in which employees are willing to come forward in the interests of system safety. Yet, no one can afford to offer a “blame-free” system in which any conduct can be reported with impunity – as society rightly requires that some actions warrant disciplinary or enforcement action. It is the balancing of the need to learn from our mistakes and the need to take disciplinary action that this report addresses. Ultimately, it will help you answer the question: “Where do you draw the disciplinary line?”

## Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)

### II. The Problem Statement

On October 12, 1999, Dr. Lucian Leape, a professor at the Harvard School of Public Health, gained the attention of a US Congressional subcommittee when he briefed them on the state of human error management in the US medical industry.<sup>1</sup> The numbers are staggering: an estimated one million people injured by errors in treatment at hospitals each year in the US, with an estimated 120,000 deaths arising from those errors.<sup>2</sup> A number three times greater than those who die in automobile accidents and 1000 times greater than those who die in commercial aircraft accidents, these errors are accompanied by an estimated \$33 billion price tag.

As a result of a punitive work environment and because hospital personnel (as well as most of the public) tend to regard health care provider errors as evidence of personal carelessness, most hospitals are unaware of the extent of their errors and injuries. Dr. Leape reported that only 2 to 3% of major errors are reported through hospital incident reporting systems. Health care workers often report only what they cannot conceal.

Dr. Leape went on to tell Congress that health care organizations must make error prevention a major strategic objective, and that hospitals should eliminate punitive error reporting systems so that reporting can be made “safe” for employees. Systems should be established to track error and the effectiveness of corrective measures. Regulators must become a force for error reduction rather than a force for error concealment. We must all be educated regarding the central roles of system design and corporate responsibility in managing human error.

Ultimately, Dr. Leape said, the single greatest impediment to error prevention is that

*“we punish people for making mistakes.”*

It is this very bold statement that this primer addresses. Just what is the role of punitive sanction in the safety of our health care system? Does the threat and/or application of punitive sanction as a remedy for human error help or hurt our system safety efforts?

---

<sup>1</sup> Testimony, United States Congress, House Committee on Veterans’ Affairs, Dr. Lucian L. Leape, MD, October 12, 1997.

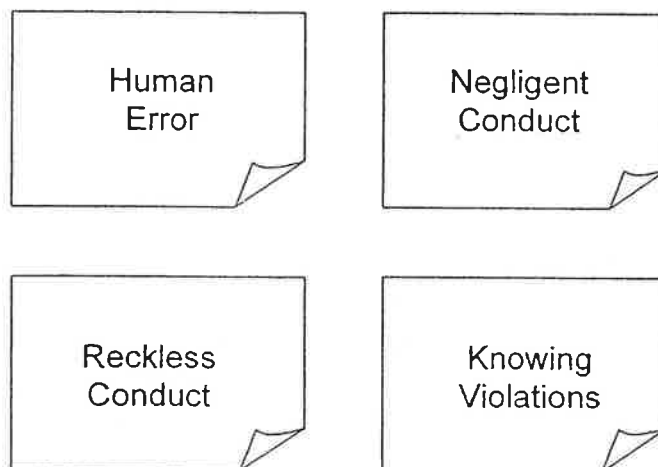
<sup>2</sup> The later released IOM report put the number of deaths at between 44,000 and 98,000 deaths in the US each year.

### III. An Introduction to Disciplinary System Theory

Determining when a health care professional warrants disciplinary sanction requires that we first attempt to define, or at least better describe, what we mean by disciplinary action. In our context, we will think of disciplinary action as harm dispensed by an authority to deter future undesirable conduct. Quite simply – punishment. Punishment that harms directly through its sanction (fine or license action) or, perhaps even worse, the often-resulting public condemnation of the individual involved.

#### A. The Four Evils

Four behavioral concepts are important to an understanding of the inter-relationship between discipline and patient safety: human error, negligence, intentional rule violations, and reckless conduct. These behavioral categories are presented here because they are the principal labels we use socially, and legally, to describe blameworthy conduct. One or more of these behavioral categories will be applied in most mishap investigations, and the label often determines when disciplinary sanction is appropriate. The question we will specifically address is whether all or only some of these labels warrant disciplinary sanction in the post-mishap setting.



## **Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

---

As you will see in the examples that follow, the “four evils” are not mutually exclusive; they overlap each other in definition - and they can all occur in the same mishap. Following is a short description of each.

### *1. Human Error*

Human Error is a social label. It may be characterized as follows:

When there is general agreement that the individual should have done other than what they did, and in the course of that conduct inadvertently causes or could cause an undesirable outcome, the individual is labeled as having committed an error.

Human error is a term that we use to describe our everyday behavior – missing a turnoff on the freeway, or picking up strawberry ice cream instead of chocolate. The threshold for labeling behavior “human error” is very low – we make errors every day with generally minimal consequences. In the health care profession, we make similar types of errors – perhaps not at the frequency of those in our off-work hours, but often with much more potential for dire consequences. We use terms like mistake, slip, and lapse to basically tell the same story – that someone did other than what they should have done, and inadvertently caused an undesirable outcome. When a physician prescribes the wrong dosage, we will likely label her actions a human error. We understand that the physician did not intend her error or its undesirable outcome even though the consequences are potentially life threatening.

### *2. Negligent Conduct*

Negligence, at least in our social dialogue, is conduct subjectively more culpable than human error. Negligence, as a legal term, arises from both the civil (tort) and criminal liability systems. Negligence is the term generally used when an individual has been harmed by the healthcare system. A basic tenant of common law is that he who is negligent must pay for the resulting damages. In most states, negligence is defined as failure to exercise the skill, care, and learning expected of a reasonably prudent health care provider.<sup>3</sup> Criminal negligence, as defined by the Model Penal Code, involves an

---

<sup>3</sup> See Washington Pattern Jury Instruction WPI 105.01 Negligence – General Health Care Provider.

## **Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

---

objective determination that a person *should have been aware* that they were taking a substantial and unjustifiable risk toward causing an undesirable outcome.<sup>4</sup>

### *3. Reckless Conduct*

Reckless conduct, alternatively referred to as gross negligence, involves a higher degree of culpability than negligence. Reckless conduct in both the civil liability and criminal systems involves conscious disregard of risk.<sup>5</sup> Reckless conduct differs from negligent conduct in intent; negligence is the *failure to recognize* a risk that should have been recognized, while recklessness is a *conscious disregard* of a visible, significant risk. Consider the term “reckless driving.” For most of us, it connotes a much higher degree of culpability than mere human error.

### *4. Intentional Rule Violations*

Most rules, procedures, and duties will require or prohibit a specific behavior. The intentional rule violation occurs when an individual chooses to knowingly violate a rule while he is performing a task. This concept is not necessarily related to risk taking, but merely shows that an individual knew of or intended to violate a rule, procedure, or duty in the course of performing a task.

## **B. Application to Transfusion Scenarios**

Consider now the application of these four labels to three transfusion scenarios. Pay attention to the labels as the conduct in each scenario gets progressively more culpable.

### *1. Scenario 1- The Memory Error*

A medical technologist receives a sample for type and crossmatch. As she brings up the patient record on the computer, the computer flashes a warning that the patient has autologous units on hold.

She goes to the refrigerator to retrieve the autologous units. Before she can get the units, someone asks her a question about an antibody identification problem. She takes a few minutes to help the other technologist. When finished, she remembers she was going to the refrigerator for two A Pos units, but gets two

---

<sup>4</sup> See Model Penal Code (1962) Section 2.02. General Requirements of Culpability.

<sup>5</sup> See Model Penal Code (1962) Section 2.02. General Requirements of Culpability.



## **Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

homologous units rather than the two autologous units. The two homologous units are crossmatched and labeled for the patient.

The issuing technologist looks at the pick-up slip and goes to get the two units off the shelf. During the computer crossmatch, a computer warning indicates that the patient has autologous units available. The issue technologist notices that she has two homologous units. The issue is delayed until the autologous units are made available.

This event involves a simple memory error. The system is robust and catches the error; however, a technologist has made an error and has to rely on system defenses to catch it. What should happen to this technologist? Clearly, from a system safety perspective, she should be part of the process of learning how the system can be improved. Does the system safety perspective also require that she be disciplined?

With respect to the “four evils,” into which category has our nurse fallen? The answer is illustrated in the table below:

<b>Scenario 1 - Analysis of the Four Evils</b>			
<b>The Evil</b>	<b>Definition</b>	<b>Apply to this event?</b>	<b>Rationale</b>
Human Error	Should have done other than what they did.	Yes	Technologist pulls homologous blood rather than what she should have pulled – the autologous blood.
Negligence	Failure to exercise expected care. Should have been aware of substantial and unjustifiable risk.	Yes	Technologist pulls homologous blood rather than what she should have pulled – the autologous blood. Expectation is that technologist will pull correct blood.
Recklessness	Conscious disregard of substantial and unjustifiable risk.	No	Technologist was not aware of risk she was taking – either in pulling wrong blood, or in being distracted by interruption to work flow.
Intentional Rule Violation	Knowingly violates a rule or procedure.	No	No intentional violations present.

In this first scenario, the technologist made a simple error in not remembering the exact blood specification she was to pull. The system worked in that the issue technologist caught the error before the blood made it to the patient. In any high-risk system, it is



## **Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

---

wise to design the system so that single human errors (single point failures) cannot directly lead to a catastrophic result. From a learning perspective, it is helpful to understand the types of distractions that can arise, and how employees react to the interruptions. In this case, the system could be altered to re-confirm the computer order before continuing after any interruption. Many aircraft pilots rely on this process – repeating the pre-flight checklist when any interruptions occur.

### *2. Scenario 2 – The Misplaced Tube*

A new transfusion service phlebotomist is on the early morning shift drawing samples on the hospital floor. She checks Ms. Jones’ requisition and armband before she draws her samples.

Ms. Jones is really annoyed about the bright lights the phlebotomist has turned on, and the phlebotomist is trying to placate Ms. Jones by turning them off quickly. She knows that there is a strict procedure to label tubes at the bedside, but as she has already positively identified the patient, and this is the only set of tubes she has, she decides to label the tubes at the nurse’s station.

She lays the tubes down at the nurse’s station and begins labeling. However, a nurse comes to the nurse’s station with an unlabeled tube of blood and lays it down nearby. Not noticing this, the phlebotomist mistakenly thinks one of her tubes has rolled away. She picks up the nurse’s tube and also labels it with Ms. Jones’s information.

Ms. Jones is a new patient and her blood type is unknown. The mislabeled tube is used to type and cross units for her. Ms. Jones has a moderately severe transfusion reaction when the first unit is being transfused.

This event adds one element not present in the first scenario – the knowing violation of procedure. Here, just as in the first scenario, the phlebotomist is trying her best to serve the needs of her patient. She wants to handle the blood safely, but she wants to comfort her patient by turning off the light as soon as she can. Mislabeled the blood is a negligent error, and she has knowingly violated hospital procedure by labeling the blood at the nursing station. From a system safety perspective, what should be the outcome of this event? This particular phlebotomist learned the risks associated with labeling blood at the nursing station. Others could learn the same lesson. From a system perspective, are there changes that can be made to improve the tolerance of the system to this type of error? Could labels be automatically generated at the bedside? This is one event – but the precursors to the error in this mishap are the same precursors that might someday result in a fatality. To improve system safety, this event should be analyzed, among other events in the organization, to determine where these particular contributors to error fit into the risk assessment of the blood handling system.

**Patient Safety and the “Just Culture:” A Primer For Health Care Executives  
Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

---

Scenario 2- Analysis of the Four Evils			
The Evil	Definition	Apply to this event?	Rationale
Human Error	Should have done other than what they did.	Yes	Phlebotomist mis-labels blood.
Negligence	Failure to exercise expected care. Should have been aware of substantial and unjustifiable risk.	Yes	Phlebotomist mis-labels blood. Expectation is that phlebotomist will label blood correctly.
Recklessness	Conscious disregard of substantial and unjustifiable risk.	No	Mislabeled the blood was an unjustifiable risk – however the mislabeling was inadvertent. Violation of the procedure was conscious; however, nurse did not perceive a significant and unjustifiable risk in labeling blood at nursing station.
Intentional Rule Violation	Knowingly violates a rule or procedure.	Yes	Policy requires that blood be labeled at bedside. Phlebotomist knows of policy and chooses to deviate to placate disturbed patient.

From a disciplinary perspective, this event poses a difficult dilemma. Should disciplinary action be taken against the phlebotomist in this case? Does the presence of an intentional rule violation influence the decision? Would other phlebotomists or nurses have done the same to ease the disturbance to the patient? Could a supervisor counsel the phlebotomist without taking formal disciplinary action? From a learning perspective, would the phlebotomist have told a different story had she known that an intentional violation of procedure would have subjected her to possible disciplinary sanction? Would the event description instead have been a story of adherence to procedure – and no idea on the part of the employee how the blood could have been mislabeled?

## Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)

---

### 3. Scenario 3 – *The Reckless Technologist*

The evening shift of the transfusion service had three technologists on duty, two bench technologists and one supervisor.

One of the bench technologists issued a unit of blood. The procedure called for two technologists to manually review the patient and unit information before issue. The other bench technologist was on her dinner break, leaving the supervisor as the second checker. The issuing technologist had a personality conflict with the supervisor and avoided speaking to her.

The issuing technologist chose not to ask the supervisor to review the unit. She falsified the other technologist’s initials in the box indicating the review had been performed and issued the unit.

The correct unit was issued, and there was no patient harm. However, the other bench technologist noticed that her initials had been falsified and reported it to the supervisor.

This event demonstrates the most culpable conduct of the three scenarios. In this case, you probably had both an analytical reaction and an emotional reaction to the technologist’s conduct. The difference in this case is the introduction of the employee’s reckless conduct.

What is it that really separates this technologist from the technologist and phlebotomist in the previous scenarios? Specifically, is it the reckless conduct *per se* or is it the intentional violation of procedure? In the second scenario, the technologist knowingly violated the procedure to label blood tubes at bedside, but the technologist’s behavior in this event is, for most people, far less culpable than the technologist’s behavior in the third scenario. Disciplinary system research shows that we react more strongly to the risk-taking behavior of others, than to their *per se* adherence to policies or rules.<sup>6</sup> Consider your view of the driver you see weaving in and out of lanes ahead of you. Are you reacting to the violation of traffic rules, or to the risk that you know (or at least assume) the driver is taking? Do you have the same reaction to those around you who are knowingly exceeding the speed limit? Probably not. If you are like most people, culpability is based upon our perceptions of risk-taking behavior, not on our perception of whether the individual knew they were violating policy.

---

<sup>6</sup> Marx, David. The Link Between Employee Mishap Culpability and Commercial Aviation Safety, Seattle University School of Law, January 30, 1998.

**Patient Safety and the “Just Culture:” A Primer For Health Care Executives  
Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

---

Scenario 3 - Analysis of the Four Evils			
The Evil	Definition	Apply to this event?	Rationale
Human Error	Should have done other than what they did.	Possibly	Possibly. The term human error is generally used for far less culpable conduct.
Negligence	Failure to exercise expected care. Should have been aware of substantial and unjustifiable risk.	Yes	In the criminal version of negligence the technologist not only <i>should have been aware</i> , but <i>was aware</i> of the risk. Meets and exceeds the threshold for criminally negligent conduct. In the civil liability system, although the technologist did not exercise due care, there are no damages – technically, the technologist is not negligent.
Recklessness	Conscious disregard of substantial and unjustifiable risk.	Yes	Technologist knew of risk of skipping second set of eyes review – but due to personality conflict with supervisor decided to forego the review. The risk of her conduct was significant and unjustifiable, and it could likely be shown that she knew of the risk she was taking.
Intentional Rule Violation	Knowingly violates a rule or procedure.	Yes	It was a knowing violation to forgo the review and sign on behalf of a person who did not do the review as required.

So what do you do with the technologist in this case? How do you balance the competing needs of system safety objectives and discipline for this event? What, if anything, can you learn from the event to prevent similar events in the future? Are there system features that could be changed to reduce the likelihood of similar events?

Anyone who is old enough to read this report has likely already formed a good sense of his or her own justice system. Compare it to the “four evils” defined earlier. You know what conduct bothers you, you know when you are willing to say “to err is human,” and you know when you would take disciplinary action against an individual in a mishap. With your own sense of justice better articulated through your understanding of the “four evils,” consider the following disciplinary policies of organizations and regulatory agencies having oversight of high-risk industries.

## Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)

### C. Disciplinary Decision-Making Strategies

We will now review three types of disciplinary policies: those predominantly considering outcome, those considering adherence to procedures, and to those considering risk.

#### 1. *Outcome-Based Disciplinary Decision-Making*

While it may seem strange to some, much of our disciplinary decision-making hinges upon outcome. If a nurse makes an error that causes no harm, we consider the nurse to be lucky. Yet, if another nurse makes the same error resulting in injury to a patient, we consider the nurse to be blameworthy, and disciplinary action may follow. The social sciences call this a severity bias - the more severe the outcome, the more blameworthy the actor.<sup>7</sup>

Until recently at one hospital in Texas, any nurse who made a medication error was given a score based upon the circumstances of the event.<sup>8</sup> Error scores ranged from 1 point (wrong time) to 5 points (incorrect medication). Method errors ranged from 2 points (topical) to 6 points (epidural). The class of drug used added from 1 point (antacids) to 6 points (blood solutions). According to the disciplinary policy, accumulating 1 to 18 points warranted coaching, 19-36 warranted a written warning, 37-54 points required mandatory attendance at an individualized remedial medication review, and finally, more than 55 points left the nurse open to termination for gross negligence. Now consider the point values associated with the *outcome* of the medication error: 5 points for no harm, 15 points for moderate injury, 25 points for severe injury, and 70 points for death.

A disciplinary scheme where outcome plays such a dominant role is questionable. Theoretically, an intoxicated nurse who causes no harm through her error could be in the 10-20 point range, where a well-meaning nurse who kills his patient would be in the 80's or 90's. In this system, it is the outcome that drives the disciplinary decision-making. If system safety is the goal of disciplinary action, how is this supported by a system that allows the intoxicated - but fortunate - nurse to remain, and the well-meaning nurse to be terminated? This is a fundamentally flawed system, based upon the notion that we can totally control our outcomes. In managing human error, we can only control our *intended* behaviors to reduce our likelihood of making a mistake, but we cannot truly control when and where a human error will strike.

---

<sup>7</sup> See Fiske, S. and Taylor, S. *Social Cognition*, New York; McGraw-Hill, 1991.

<sup>8</sup> Parkland Hospital, Dallas Texas.



## **Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

---

At times, basing disciplinary decision-making on outcome is necessary. In our criminal system, drunk drivers suffer far greater consequences for killing someone than for merely damaging property. The driver’s intent, to drink and drive, is the same, yet the outcome is very different. As a society, we have shaped our legal system around not only intent, but around the notion that the punishment should fit the severity of the crime. Where an individual has made a decision to cause harm, the greater the intentional harm, the greater the evil and hence the greater the punishment required.

What is troublesome about outcome-based disciplinary decision-making is that the reckless individual who does not injure another sometimes receives less punitive sanction than the merely erring individual who has caused injury. Yet, whether disciplinary sanction will be effective is dependent on the intent of the erring individual. Punishment deters those who consciously choose to disregard risk or intend to harm others, but has little to no impact on the individual who does not intend to make a mistake.

### *2. Rule-Based Disciplinary Decision-Making*

Rule-based disciplinary decision-making is the easiest to understand. Most high-risk industries have rules, policies, and procedures intended to prevent mishaps from occurring. Some are based upon the outcome; some control behavior. Most outcome-based rules merely state that certain outcomes, such as injury to a patient, are prohibited. A behavioral rule might be a requirement to check an armband or a work hour limitation. In either case, there are two questions that need to be asked: did an individual violate a rule, and did the individual intentionally violate a rule. In many organizations today, disciplinary action is possible for any rule violation – intended or not. Those who have revised their policies to encourage learning from mishaps have raised the disciplinary threshold to intentional rule violations.

The Federal Aviation Administration has developed a system for pilot self-reports that provides an enforcement-related incentive for errors reported through the Aviation Safety Reporting System (ASRS).<sup>9</sup> The FAA will forego certificate action against the airman who reports a violation as long as the violation of Federal Aviation Regulations was “inadvertent and not deliberate,” among other considerations. In other words, when the violation is intentional, the FAA believes the need to discipline outweighs the potential

---

<sup>9</sup> U.S. Department of Transportation Federal Aviation Administration, Aviation Safety Reporting Program, Advisory Circular No. 00-46C, February 4, 1985.

## **Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

---

benefits of learning from an event. Many corporations have similar provisions – allowing an employee to report her error as long as there were no intentional violations associated with the event. It is a rational scheme – discipline for those who choose to violate, the opportunity to learn from those who violate inadvertently.

There are, however, some difficulties associated with the rule-based approach to disciplinary action. First, not all intentional violations are bad. Particularly in heavily rule-based professions, such as medicine and aviation, there will always be circumstances where the vast overlap of rules does not fit the circumstances facing the professional performing his job. If a health care provider felt it was necessary to violate a policy to save a patient, and the facts supported that conclusion, should the health care provider simply follow procedure and injure his patient? What also of malicious compliance – where a disgruntled employee knowingly follows a flawed procedure merely to cause damage to the organization? The bottom line is that we do not judge humans solely based upon whether they knowingly violated policy – but rather on whether they knew the risks they were taking increased the potential for harm (discussed in the next section).

Another problem is that intentional violations of rules and procedures occur everyday, even in high-risk industries such as health care and aviation. In commercial aviation, there is tremendous evidence of normative violations of procedure. In aircraft maintenance, one US air carrier found that over 50% of its mishaps involved a knowing violation of company policy.<sup>10</sup> Most of these violations were the result of norms that had developed over time – without the workforce’s knowledge that the norms were significantly increasing risk of a mishap. Likewise, at least one US air carrier has found that over 50% of its pilot errors involved knowing violation of policy.<sup>11</sup>

The important point is that violations in themselves are critical learning opportunities for improving safety. Much can be learned through an understanding of why certain violations become the norm. Unfortunately, in a disciplinary model that takes action against every intentional deviation from policy, there will be little learning about violations. Employees will report that they were conscientiously following procedure when the error occurs – when the facts are possibly quite different.

---

<sup>10</sup> Johnson, William. Installation Error in Airline Maintenance, Galaxy Scientific Corporation, January 2001.

<sup>11</sup> Personal communication, de-identified US air carrier.



## **Patient Safety and the “Just Culture:” A Primer For Health Care Executives Medical Event Reporting System – Transfusion Medicine (MERS-TM)**

---

### *3. Risk-Based Disciplinary Decision-Making*

Another method used to determine whether discipline is warranted, and the basis of our civil liability system, considers the intent of an employee with regard to an undesirable outcome. Negligence, gross negligence, and recklessness are all concepts related to risk creation.

Recklessness is a “high crime”- demonstrating greater intent than mere negligent conduct. If an individual intends to take a significant and unjustifiable risk, disciplinary action should be taken. Many organizations adopting a reporting culture in their efforts to learn from mistakes have raised the threshold for possible disciplinary action to reckless conduct, using discipline only to deter intentionally or knowing unsafe acts. If the act were inadvertent, such as in the case of negligence, then the employee would be safe to report in these systems. I am aware of no organization in the world, even those professing a “blame-free” disciplinary system that will not discipline an individual who has been reckless toward the safety of others.

But what to do with the negligent employee? If the employee knew and consciously disregarded the risk they were taking, the usefulness of disciplinary action – as a deterrent to both the employee in question and to other employees - cannot be ignored. If an employee had no reason to know he was creating a risk, there should be no discipline. Negligence, however, sits squarely in the middle of these two circumstances, where an employee should have known, but was unaware, of the risk they were taking. Most corporate disciplinary systems have set their threshold at negligence – that is, allowing disciplinary action where an employee should have been aware of the risk they were creating. This would be the case of the physician who writes a prescription for 100 mg of a drug rather than the intended 10 mg of the drug. Was he aware of what he had done? No. Should he have been aware? Yes.

Our civil liability system does not allow punitive sanction for negligent conduct because there is no intent to cause harm involved in negligence. Historically, negligence has been only a compensatory concept – intended to compensate the victim, not punish the negligent actor. Clearly, in medicine, negligence is the threshold for compensating victims of harm caused through the medical system. To that end, it is important to distinguish negligence and human error from reckless conduct. Negligence and human error are both terms for conduct that is generally viewed as inadvertent – the individual does not intend to engage in his error or negligence. In general, states allow for punitive damages only when the individual involved was reckless – that is, acting in conscious disregard of substantial and unjustifiable risk.