Teamwork and The “Just Culture”

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March 25, 2014
Teamwork

Adverse event evaluation and how we should determine accountability

The Just Culture
Teamwork

A successful team requires:

1. Competence
2. Commitment
3. Clarity

When things don’t go as planned, which of the above was problem?
Was is someone’s fault?
Or just bad luck?
Clinical Scenario

A spinal is placed by a resident and 4 minutes later the patient becomes profoundly hypotensive and arrests.

What should we do?
frame : picture :: water :

A. peninsula
B. island
C. lake
D. reservoir
Some Options
(Not usual the ABCDs)

A. **Do nothing**. Until he does it again.
B. **Console**. Educate him about the “rule”.
C. **Coach**. Report him for poor performance.
D. **Discipline**. Put him on probation.
What Should We Do?

A. **Do nothing.**

B. **Console.** (“We’re sorry this happened to you.”)

C. **Coach.** (“Don’t do that again.”)

D. **Discipline.**
Clinical Scenario

A spinal is placed by a resident and 4 minutes later the patient becomes profoundly hypotensive and arrests.

Let us consider:
• Is the resident at fault?
• How do we decide?
• What should we do?
A spinal is placed by a resident and 4 minutes later the patient becomes profoundly hypotensive and arrests. It’s a “rule” to cycle the NIBP machine at 1 minute intervals after an SAB, but this wasn’t done by the trainee.

So what he did is below the standard.

What should we do?
Does it matter how advanced he was in the training program (first year, second year, etc)?

A. Yes, it matters
B. No, it’s irrelevant
Does it matter whether he has ever done this before?

A. Yes, it matters
B. No, it’s irrelevant
The Elements Of A Just Culture

Strikes the balance between a blame-free culture and a punitive culture

- Blame-free = no accountability for any actions, even the ones we control
- Punitive = fault-finding and discipline for all adverse events, even the ones we do not control
Why A Just Culture?

- Blame-free, non-accountability cultures breed **cynicism**
- Punitive cultures breed **fear**
- In order to develop a high-reliability safety culture we need to strike a balance between these 2 extremes

**A Just Culture Promotes Safety**

David Marx justculture.org
Lucian Leape on Safety: What Have We Learned? (2009)

**Safety** is not about reporting, protocols, and safe practices. It’s about relationships and teamwork.

**Teamwork** is the secret of every hazardous industry that has become safe

(Examples: aviation, nuclear power)
Lucian Leape on Safety: What Have We Learned? (2009)

Teamwork

Characteristics of effective teams
   Leadership, Focus, Commitment,
   Communication, Mutual respect

To have communication & mutual respect, you must drive out **cynicism** and **fear**

So you must strike a balance between a blame-free and a punitive culture
Teamwork Isn’t Easy

An expert team is not a group of experts
Behaviors That Lead To Events

What causes adverse events?

1. No Behavior (Bad Luck)
2. Human Error (Slips, omissions)
3. At-Risk Behavior (Taking chances)
4. Reckless Behavior (Willful disregard)
You’re driving a car and you stop at a red light. It’s the first of 2 intersections, each of which has a traffic light. Your light is red; the next light is green. While you are stopped, a car approaching from behind you fails to stop and as a result collides with your car.
Bad Luck

(Nothing to be done, except perhaps offer sympathy)
Human Error: Slips, Omissions

You’re driving a car along a route you take every day. One day, inexplicably, you fail to notice a red light. You rear-end the car in front of you who was stopped at the red light.
Human Error

Nothing to correct. (We’re sorry this happened.)

My Bad!
Taking Chances

You’re driving a car and texting. One day, fairly predictably, you fail to notice a red light. You rear-end the car in front of you who was stopped at the red light.
Taking Chances

It’s time for a serious talk about risk-taking behavior and how you need to stop doing it. Now.
Willful Disregard

You’re driving a car intoxicated and texting, tweeting, and posting selfies on social media. You fail to notice a red light, etc. *(There should be consequences for this.)*

Remedial action
Punitive action
Clinical Scenario

A spinal is placed by a resident and 4 minutes later the patient becomes profoundly hypotensive and arrests.

It’s a “rule” to cycle the NIBP machine at 1 minute intervals after an SAB, but this wasn’t done.

What was this? Bad luck, Error, Risky Business, or Bad Behavior.
What Was This?

A. Bad luck
B. Error
C. Risky Business
D. Bad Behavior
Suppose:

1. The case was urgent, the resident had never done a spinal before and had not been assigned the reading that would have taught him the rule. His teaching physician didn’t know that.
Which Applies Here?

A. Bad Luck
B. Human Error
C. At-Risk Behavior
D. Reckless Behavior
Human Error

- Mistakes (lack of knowledge or incorrect understanding)
- Slips & Lapses (loss of focus or attention)
Bad Luck or Human Error

- It might be bad luck
- Or a lack of knowledge
- Or a lapse

- The correct response involves sympathy, not corrective action
Bad Luck

• Use the “Substitution Test”
• Ask whether there would have been the same result if almost anyone else was substituted for the person involved in the event
• Even if there is an error, ask whether anyone else would have been likely to make it
Suppose:

2. The resident was in the 2nd year and knew the rule, but didn’t follow the rule. The NIBP interval was set @ 3 minutes by default and the resident did not change it after he performed the spinal. He just plain forgot. Has never done anything like this before.
Which Applies Here?

A. Bad Luck
B. Human Error
C. At-Risk Behavior
D. Reckless Behavior
At-Risk Behavior

• Risk not recognized
• Risk believed justified
  – Sometimes social utility plays a role ("everyone seems to do it that way")

• Sometimes the risky behavior is promoted or supported by the system and therefore more difficult to correct.
• {Substitution Test}
Suppose:

3. What if the patient had been complaining of pain when the cuff cycled the first time and the resident decided on a longer interval for this patient because of that?
At-Risk Behavior: Choices

- Risk not recognized
- Risk believed justified
Which Applies Here?

A. Bad Luck
B. Human Error
C. At-Risk Behavior
D. Reckless Behavior
Suppose:

4. It was a senior resident who knew the rule, but deliberately set the NIBP interval @ 2.5 minutes. He has done this before and been counseled about it.
Which Applies Here?

A. Bad Luck
B. Human Error
C. At-Risk Behavior
D. Reckless Behavior
Reckless Behavior

- Conscious disregard of a risk
- Unreasonable decision
Clinical Scenario

It’s really not about an outcome, but about a process of care that produces a threat to safety.

It can be a “near-miss” or there can be an adverse event. That’s not the point.

Avoid the severity bias that ascribes greater importance if there is an adverse event.
How Should We Respond To The Resident’s Actions?

A. Do nothing. Until he does it again.
B. Console. Educate him about the “rule”.
D. Discipline. Put him on probation.
E. I need more information before I can decide
Last Question

A. Do nothing. Until he does it again.
B. Console. Educate him about the “rule”.
D. Discipline. Put him on probation.
E. I need more
In A Just Culture, The Response Depends Upon The Situation

1.  Bad Luck: Console
2.  Human Error: Console (unless it’s a repeated pattern)
3.  At-Risk Behavior: Coach and Document
4.  Reckless Behavior: Discipline
Just Culture Takeaway Points

Accountability is important but only when the results are due to specific decisions. Use the substitution test. Only be punitive in response to neglect and repeated rule-breaking. Suspend judgment until you have the whole story.