

Error Prevention in a Just Culture: Avoiding Severity Bias

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Consider the following scenario: An experienced surgeon sees a new piece of equipment at a conference. Back at the hospital, a sales representative persuades him to use the equipment for a procedure. He has never used the equipment before and accidentally punctures the patient's bowel. The surgeon repairs the bowel, and the patient recovers fully. The operating room (OR) has a policy that says new equipment will be officially approved and training will be conducted prior to its use.

How would your health care organization respond to the physician in this scenario? Would you discipline or punish him? Would you encourage a different course of action, issue a warning, or take no action?

Now, consider exactly the same scenario with a different outcome: The patient dies as a result of the accidental puncture. How would this outcome change your organization's response?

This column discusses a phenomenon known as *severity bias*. Severity bias is present when the severity of an actual outcome influences how we think

about the person involved or how we respond to the person if we have managerial authority. In other words, the level of actual harm determines whether discipline or punishment is used. An organization with a just culture will recognize how this bias enters into daily thinking and take steps to avoid its dangerous influence.

Types of Severity Bias

Severity bias can involve the following:

- Punishing or disciplining a person who made a human error or engaged in an at-risk behavioral choice, regardless of the outcome
- Not addressing the behavior at all when no adverse outcome results, even though harm could have occurred in similar circumstances.
- Addressing the behavior in a non-punitive way.

Severity bias affects us all—on individual, organizational, and even societal levels. In the first case, punishing someone who has committed an error that causes harm might turn out to be an overreaction. Human errors are inevitable; each of us makes mistakes, doing other than what was intended. After we've made a mistake with an adverse outcome, we usually understand the risk involved and work to make improved choices in the future.

The key to success, however, lies primarily in improving our system design. We can design systems that allow us to mitigate the effects of predictable human fallibility and prevent adverse outcomes. (Error-tolerant systems have proven very effective, from the tether attached to the gas cap on our cars to safeguards embedded in every nuclear reactor ever built.)

While many people will want to blame someone when something goes wrong, this is a dangerous game to play if we believe it's the best strategy for reducing the risk of future accidents. Overreacting can potentially cause harm to our culture by driving reporting of human error below the surface, so that individuals are hesitant to come forward to admit their mistakes and risky choices for fear of discipline or punishment. In this punitive environment, managers are unable to see the mistakes and risky behaviors that are hidden from view.

In contrast, the second form of the severity bias is failing to take appropriate action when harm does not occur. Many organizations struggle to hold people and systems accountable consistently. Oftentimes, risky behaviors may be frowned upon, yet when nothing bad happens as a result, we are lulled into complacency, thinking that the behavior wasn't that bad.

In other instances, we may "turn a blind eye" to the behavior or even reward an employee who is getting great outcomes. In these circumstances, we simply learn the wrong lessons from our risky behaviors—reinforcing at-risk or reckless choices because no harm occurred.

Have you heard the phrase "No harm, no foul?" That is the lesson we learn repeatedly in our daily lives when we engage in risky behaviors, such as talking on a cell phone while driving. In health care, it might be a nurse skipping a second patient identifier or a pharmacist signing for a prescription filled by a technician without double-checking the order, or a hospital OR manager allowing a surgery without an up-to-date patient history and physical.

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Most of the time, our risky behaviors will not harm anyone. If an accident occurs, we're often surprised at what should have been a predictable result.

For example, drunk driving causes roughly 12,000 deaths each year in the United States, according to the National Highway Traffic Safety Administration. Yet, some states allow individuals to be arrested as many as five times for driving under the influence of alcohol before imposing a criminal penalty, unless a fatality occurs. If we are serious about reducing the number of these preventable deaths, should we really wait until the fifth occurrence to impose a significant deterrent? If yes, then why would we be surprised when the drunk driver eventually does run a red light and kill an unsuspecting family traveling in a minivan?

The End Does Not Justify the Means

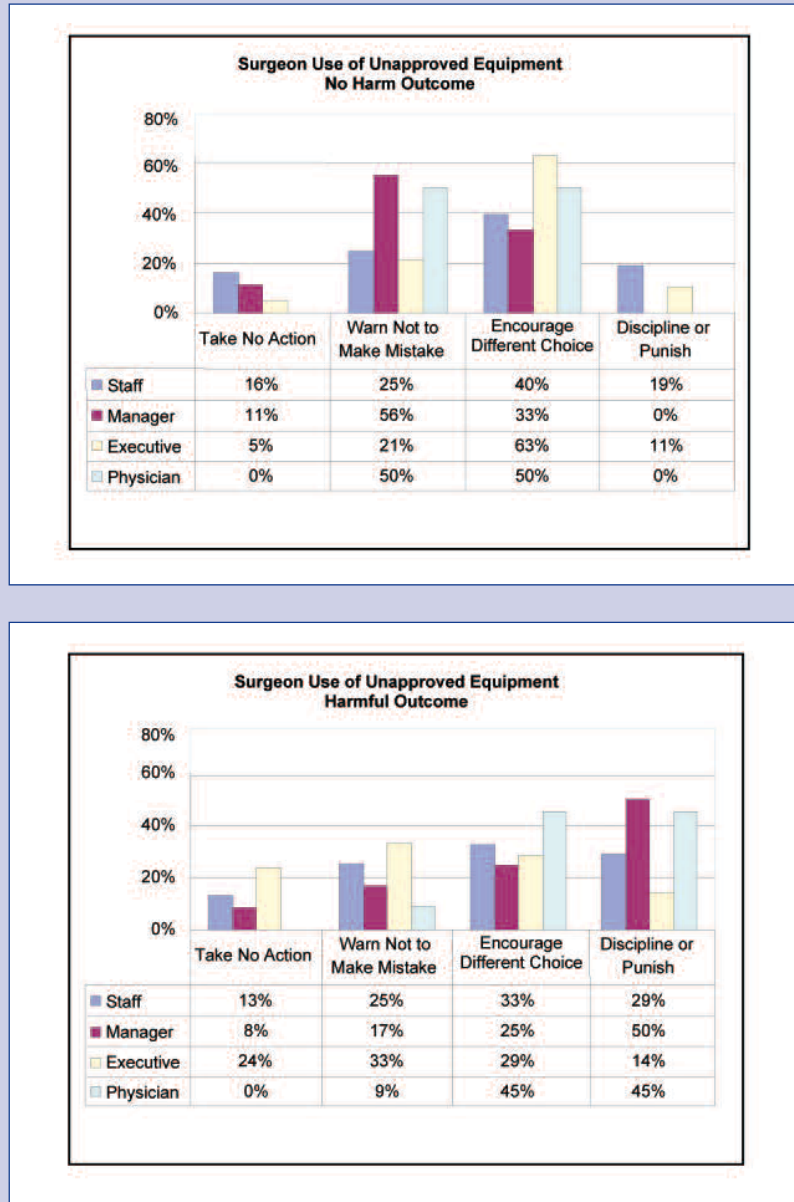
At the beginning of this article, we asked how your organization would respond to a specific behavioral choice, given two very different outcomes—one involving patient harm (death) and another involving full recovery. The charts in Figure 1 (at right) summarize the responses by job category within a typical health care organization.

In this scenario, we see how strong severity bias can be. In this hospital, many more respondents said that discipline or punishment should be the result when the patient is harmed. These are typical results.

The challenge for all of us is to strive for consistency of response whenever a risky behavior is recognized. We must learn our lessons from the risk of the adverse outcome that is present in systems and our behavioral choices, not simply the actual outcome that occurs.

In order to improve patient outcomes, health care organizations must

Figure 1. Severity Bias Scenario



understand human fallibility—the simple fact that we all make mistakes. Similarly, we must recognize that at times we will all drift, cutting corners or moving away from safe behaviors when we perceive that no consequences will come of our actions.

Understanding this about ourselves, we should then look to managing our choices so as to lower the risk of bad outcomes. We do this by striving to

create safe systems and making safe choices that align with our values. We should pay particular attention to those choices that we know can lead to harm but usually don't and work to make better choices before something bad finally happens.

An organization that has a just culture will resist the urge to say “no harm, no foul” and will treat a risky choice as a precursor to a bad outcome.



A just culture takes a systems-based approach to patient safety but holds health care providers accountable for negligence or risky behaviors.

In doing so, the organization must work consistently to manage risk before the next accident occurs. Error prevention in a just culture is not about expecting perfection. It is about understanding our limitations and working to maximum reliability by improving both our choices and the system around us.

Editor's Note: *The views expressed in this article are those of the author and not of The Joint Commission or Joint Commission Resources.* **PS**

Correction:

The "Caring for the Delirious Patient" article on page 9 of the January 2010 issue of this newsletter states "The priority is to treat the pain, but we can look for the least toxic medications to treat pain. Perhaps we can start with around-the-clock acetaminophen (1 mg four times a day)."

Acetaminophen does not come in 1 mg doses, the article should have said 1 gram, four times a day.

We regret the error.

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