Balancing "No Blame" with Accountability in Patient Safety

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This year marks the 10th anniversary of the Institute of Medicine's report *To Err Is Human*,[1] the document that launched the modern patient-safety movement. Although the movement has spawned myriad initiatives, its main theme, drawn from studies of other high-risk industries that have impressive safety records, boils down to this: Most errors are committed by good, hardworking people trying to do the right thing. Therefore, the traditional focus on identifying who is at fault is a distraction. It is far more productive to identify error-prone situations and settings and to implement systems that prevent caregivers from committing errors, catch errors before they cause harm, or mitigate harm from errors that do reach patients.[2,3]

Most health care providers embraced the "no blame" model as a refreshing change from an errors landscape previously dominated by a malpractice system that was generally judged as punitive and arbitrary. And this shift has unquestionably borne fruit. For example, rather than trying to perfect doctors' handwriting and memories, computerized systems catch medication errors before they reach patients.[4] Implementing simple checklists markedly increases the use of evidence-based prevention strategies, leading to fewer surgical complications and bloodstream infections associated with central venous catheters.[5,6]

But beginning a few years ago, some prominent health care leaders began to question the singular embrace of the "no blame" paradigm. Leape, a patient-safety pioneer and early proponent of systems thinking,[2] described the need for a more aggressive approach to poorly performing physicians,[7] and the Joint Commission has made addressing the problem of disruptive caregivers a priority.[8] Goldmann identified the need to create accountability for failure to perform hand hygiene.[9] Rather than a "no blame" culture, Marx promoted a "just culture," which differentiates blameworthy from blameless acts.[10,11]

Many health care organizations (including our own) have recognized that a unidimensional focus on creating a blame-free culture carries its own safety risks. But despite this recognition, finding the appropriate balance has been elusive, and few organizations have implemented meaningful systems of accountability, particularly for physicians. In this article, we describe some of the barriers to physician accountability, enumerate patient-safety practices that are ready for an accountability approach, and suggest penalties for the failure to adhere to such practices. We focus on situations in which the action (or inaction) of individual physicians poses a clear risk to patients, rather than on the broader issues of clinical competence or disruptive behavior; readers who are interested in the latter issues are referred to other sources.[7,12,13]

"NO BLAME" VERSUS ACCOUNTABILITY

A decade ago, rates of hand hygiene in most American hospitals were shameful, often below 20%. As attention began to focus on unacceptably high rates of health care–associated infections, most organizations treated low hand-hygiene rates as a systems problem.[14] Many launched "hand hygiene campaigns," accompanied by internal dissemination of hand-hygiene rates and admonitions by senior administrators to improve the rates (sometimes accompanied by financial incentives). Hand-gel dispensers were placed in or near every patient's room. A few institutions even brought in human-factors engineers to assess the overall hand-hygiene system and recommend process changes. To the degree that the failure to clean hands was due to flawed systems or provider ignorance, these actions made sense.

Despite these efforts, most hospitals continue to have hand-hygiene rates that range from 30 to 70%, and few have sustained rates over 80%. We have had the experience of asking frustrated hos-

pital safety and infection-prevention leaders how they planned to improve on low rates. The usual response: "We're trying to improve the system."

Like Goldmann,[9] we believe that in most U.S. hospitals, this answer is no longer the correct one. In 2009, low hand-hygiene rates are generally not a systems problem anymore; they are largely an accountability problem.

A similar argument can be made about other commonsense safety practices, such as using a checklist to reduce bloodstream infections, marking the surgical site to prevent wrong-site surgery, and performing a preoperative "time-out." Although there may never be randomized trials proving the effectiveness of some of these procedures (particularly those addressing unusual events, such as wrong-site surgeries), the practices mirror those used in other safe industries, comport with most theories of error causality, are recommended by most safety authorities and required by accreditors, and are associated with relatively low cost, complexity, and risk. Yet we have heard many examples of physicians who fail (and sometimes even refuse) to perform such procedures. Typically, their institutions tolerate such behavior by reacting with shoulder shrugs rather than penalties.

It is not that hospitals never punish members of their medical staff. In many American hospitals, physicians can lose their staff privileges for failing to sign discharge summaries or operative notes. These rules are promoted by regulatory requirements and financial imperatives, since hospitals cannot bill most payers without signed notes. Because these transgressions are considered administrative rather than clinical (and thus do not cross invisible lines with respect to intruding on clinical-practice habits), hospital leaders have felt comfortable establishing penalties. Not so for safety rules.

The costs of the failure to enforce safety standards are real. For example, approximately 4000 wrong-side surgeries are performed annually in the United States.[15] Although it is likely that most such errors are preventable with adherence to the Universal Protocol (which includes surgical-site marking and a preoperative time-out),[16] physicians frequently skip some required steps.[17,18] Many experts believe that many, if not most, of the estimated 100,000 annual deaths from health care–associated infections in the United States

could be prevented by strict adherence to infection-control practices, including hand hygiene.[6,19,20] But here too, compliance is spotty. As long as transgressions carry no risk of penalty, some providers will ignore the rules, believing that they are not at risk for the mistake that the practices are designed to prevent, that they are too busy to bother, or that the practice is ineffective. Some of their concerns may be legitimate, but for a growing number of safety practices, they are not.[21]

WHY IS ENFORCEMENT OF SAFETY STANDARDS SO WEAK?

Our failure to create real accountability for patient safety partly represents a fundamental misunderstanding regarding both how other, safer industries carry out their safety activities and the nature of errors. It is true that most errors are innocent slips committed by competent and committed caregivers and are best dealt with by focusing on improving systems rather than people. But as James Reason, the father of modern error theory and "systems thinking," emphasizes, every safe industry has transgressions that are firing offenses.[22] The pilot who neglects to use a checklist before takeoff would not be allowed to fly (not to mention that the copilot would never agree to take off). In most meatpacking plants, workers are monitored by remote video and are held accountable for performance.[23] In these industries, once a reasonable safety rule is implemented and vetted (since some rules create unanticipated consequences or work-arounds and need to be reworked after initial implementation), failure to adhere leaves the world of "no blame" and enters the domain of accountability.

Although finding the right balance between "no blame" and accountability is tricky for all caregivers, we believe it is particularly challenging in cases involving physicians. In American hospitals, most providers (e.g., nurses and pharmacists) work for the organization, which typically has relatively clear lines of authority and procedures for dealing with failure to follow accepted practices. On the other hand, physicians have traditionally been individual entrepreneurs,[24,25] not employees, and thus are subject only to weak peer enforcement through medical staff structures. Not only do peers often recoil from disciplining "one of our own," but hospitals have been reluctant to

punish physicians for fear of alienating them and losing the business they bring in.[26] But as Kissinger first noted, "weakness is provocative,"[27] and the tradition of lax enforcement of safety rules has led too many physicians to ignore them.

A PRESCRIPTION FOR INDIVIDUAL ACCOUNTABILITY IN PATIENT SAFETY

Before the failure to adhere to a safety standard results in individual blame and punishment, we must not forget that such failures often are due to systems factors. For example, a given safety practice may be supported by weak evidence and providers may worry about unexpected consequences for their patients.[25] Moreover, providers may not know what behavior is expected of them, what the underlying rationale for the behavior is, or how the behavior is being audited. Dysfunctional systems, which are sometimes created by providers or administrators who lack essential training in human-factors and systems engineering, may make it too hard to adhere to the practice, inviting work-arounds.[28] Systems thinking remains a powerful concept, and expecting strict adherence to safety standards before addressing the relevant systems issues would be a mistake.

Moreover, we do not want an environment so punitive that a single lapse results in punishment, unless such an error is both deliberate and egregious. The question we are addressing is not what happens to the busy or distracted caregivers who forget to clean their hands or perform a time-out once. Rather, it is what happens when they do so habitually and willfully, despite education, counseling, and systems improvements.

Finally, punishment, when it is meted out, needs to be proportional and just. Forgetting to sign a surgical site twice might result in a loss of operating room privileges for 2 weeks, not a year. For transgressions that may be committed by different kinds of caregivers (e.g., both nurses and doctors or both low-revenue family physicians and high-revenue neurosurgeons), punishment must be fair. If persistent failure to clean hands results in a weeklong staff suspension and a reeducation requirement for physicians, it should not result in firing for nurses. Table 1 articulates a set of principles, informed by Reason's work,[22] for individual accountability for safety standards, and in an extension of Gold-

mann's example,[9] applies the principles to the case of hand hygiene.[29-31] Table 2 lists the patient-safety practices that seem ready for such an accountability framework. The list is likely to grow as stronger evidence emerges on ways to prevent serious adverse events, such as health care–associated falls, nosocomial infections, and complications after hospital discharge.[32]

FINDING A WORKABLE BALANCE

As we enter the second decade of the safety movement, while the science regarding improving systems must continue to mature, the urgency of the task also demands that we stop averting our eyes from the need to balance "no blame" and accountability. "No blame" is not a moral imperative — and even if it seems that way to providers, it most definitely does not to patients and their advocates. Rather, it is a tactic to help us achieve ends (safe and high-quality care) for which we will, quite appropriately, be held accountable. Said another way, "no blame" is a tool, and often an extraordinarily useful one. But for some mature patient-safety practices, it is simply the wrong tool.

Finding this balance will be challenging. We recognize that reasonable people will differ on many of the details and that individual organizations may need customized approaches. To move the debate forward, we have chosen to be relatively explicit about suggested penalties for selected transgressions (Table 2), hoping that organizations and caregivers will use them as "straw men" to generate their own policies. Our goal is simply to promote conversations and meaningful action. Until now, we have shuffled this issue to the bottom of the deck, preferring to work on easier, less contentious safety activities, such as computerization and checklists. It is time to raise this topic to the top of our agenda.

Part of the reason we must do this is that if we do not, other stakeholders, such as regulators and state legislatures, are likely to judge the reflexive invocation of the "no blame" approach as an example of guild behavior — of the medical profession circling its wagons to avoid confronting harsh realities, rather than as a thoughtful strategy for attacking the root causes of most errors. With that as their conclusion, they will be predisposed to further intrude on the prac-

Table 1. Prerequisites for Making the Choice to Punish Providers for Not Adhering to a Patient-Safety Practice, Using the Example of Hand Hygiene.

Prerequisite	Example of Hand Hygiene
The patient-safety problem that is being addressed is important.	Rates of health care–associated infections are unacceptably high, resulting in serious morbidity and mortality.[19]
The literature or expert consensus strongly supports adherence to the practice as an effective strategy to decrease the probability of harm.	Many studies and long-standing expert consensus support the value of hand hygiene,[20] and health care–associated infections are now reported publicly and are subject to "no pay" initiatives.[29]*
Clinicians have been educated about the importance of the practice and the evidence supporting it.	Lectures, reminder systems, academic detailing, dissemination of literature, and other steps to educate caregivers have been completed.
The system has been modified, if necessary, to make it as easy as possible to adhere to the practice without disrupting other crucial work or creating unanticipated negative consequences; concerns by providers regarding barriers to compliance have been addressed.†	Hand-gel dispensers have been placed in convenient locations throughout the building; dispensers are never empty and work well (e.g., they do not squirt gel onto providers' clothes).
Physicians, other providers, and leaders have reached a consensus on the value of the practice and the process by which it will be measured; physicians understand the behaviors for which they will be held accountable.	Meetings have been held with relevant provider groups, including medical staff, to review the evidence behind hand hygiene, the rates of hospital-acquired infections, and the steps that have been taken to optimize the system.
A fair and transparent auditing system has been developed, and clinicians are aware of its existence.	Providers know that observers will periodically audit hand-hygiene practices; observers can determine whether providers adhere to the practices, even if hands are cleaned inside patients' rooms (including the use of video[23] or systems that sound an alarm when providers approach patients' beds without using nearby hand-cleaning dispensers).
Clinicians who do not adhere to the practice once or perhaps twice have been counseled about the importance of the practice, about the steps that have been taken to make it easy to adhere, and about the fact that further transgressions will result in punishment; the consequences of failure to adhere have been described.	A physician, for example, might receive a warning note or be counseled by a department chair after the first or second observed transgression.
The penalties for infractions are understood and applied fairly.	Chronic failure to clean hands will result in a 1-wk suspension from clinical practice, accompanied by completion of a 2-hr online educational module on infection prevention.

* Because of the vigorous regulatory and reporting environment in patient safety, it is likely that if the first two criteria are met, the practice will be one that is either mandated by an accrediting organization (such as the Joint Commission) or that adherence to the practice, or instances of the patient-safety problem it addresses, are being publicly reported or are the subject of financial penalties (e.g., through Medicare's "no pay for errors" initiative).[29] However, we do not believe that such external pressures should be the sole reason that a practice reaches the level of punishment, since some regulated or publicly reported safety standards are flawed.[30] On the other hand, some safety practices may meet the first two criteria before they are regulated or reported publicly, and such practices should be candidates for the above approach.

† In light of the complexities of the health care workplace, it is important that staff members with training in systems engineering and human factors be involved in the creation of new systems of care wherever possible.[31]

tice of medicine, using the blunt and often politicized sticks of the legal, regulatory, and payment systems.

Having our own profession unblinkingly deem some behaviors as unacceptable, with clear consequences, will serve as a vivid example of our professionalism[33] and thus represent our best protection against such outside intrusions. But the

Table 2. Examples of Patient-Safety Practices, with Suggested Penalties for Failure to Adhere to Practice.

Patient Safety Practice	Suggested Initial Penalty for Failure to Adhere to Practice*
Practicing hand hygiene	Education and loss of patient-care privileges for 1 wk
Following an institution's guidelines regarding provider-to-provider sign-out at the end of a shift	Education and loss of patient-care privileges for 1 wk
Performing a "time-out" before surgery	Education and loss of operating room privileges for 2 wk
Marking the surgical site to prevent wrong-site surgery	Education and loss of operating room privileges for 2 wk
Using the checklist when inserting central venous catheters	Counseling and review of evidence,[6] loss of catheter-insertion privileges for 2 wk

* These penalties would be applied only in cases in which a clinician did not respond to initial warnings and counseling. Continued failure to adhere to the practice after the initial penalty would lead to permanent loss of clinical privileges (for physicians) or firing, in keeping with the relevant medical staff or human resource policy. Stress management and other behavioral interventions should be considered as possible adjunct approaches when a caregiver chronically fails to adhere to agreed-upon safety standards.[32]

main reason to find the right balance between "no blame" and individual accountability is that doing so will save lives.

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