It's *just* culture, so what?

Ponder for a moment any of the times that you or your colleagues were involved in a medical or medication incident – an incorrectly processed prescription, a miscalculated dose, or ordering a treatment intervention for the wrong patient perhaps?

In the wake of such an incident, how did you or your colleagues react? Perhaps you experienced the tensing up upon realizing the error, followed by the desperation of looking for a solution. What are the underlying causes of your reaction?

Is it fair that healthcare professionals should be exclusively blamed for or be held accountable for the failings of a healthcare system that they do not control? What are the problems with such a culture? Are there alternatives?

MINDFUL ORGANIZATIONS CONTINUALLY LEARN, ADJUST, AND REDESIGN SYSTEMS FOR SAFETY AND MANAGE BEHAVIOURAL CHOICES MATURELY

BLAME CULTURE

It is characterized by blame being attributed to outcomes rather than the actions leading to or the systematic factors that contributed to the outcomes. Disciplinary action is usually carried out against the healthcare professional(s) closest to the incident and the punishment is dispensed in order to deter future undesirable behaviour. Reprimands range from public condemnation and shame, documentation of disciplinary action in employee personnel files, and in extreme cases, termination.

The typical response to a culture of blame is characterized by an unwillingness to take risks or accept responsibility for mistakes for fear of criticism or punishment. This causes people to blame each other in order to avoid the punishment. Healthcare practitioners will likely remain silent in response to performance problems, near misses, or professional errors. Such mistrustful silence will make incident analysis harder and more difficult to identify existing vulnerabilities in organizational processes that may inevitably result in recurring errors, regardless of the professional performing the task.

JUST CULTURE: AN ANTIDOTE

In this type of culture, the goal is not blame but rather process improvement, ultimately to advance patient safety. Process improvement is a disciplinary approach in which an organization learns and improves by openly identifying and examining its own weaknesses. Members can openly question existing practices, express concerns, and admit mistakes without suffering ridicule or punishment.

The complexity of the situation, determining factors that "allowed" or even "encouraged" the error, are considered. The individuals involved receive constructive feedback and fair-minded treatment. This kind of culture fosters mindfulness throughout an organization. Mindful organizations continually learn, adjust, and redesign systems for safety and manage behavioural choices maturely.

However, the main issue with this type of culture is that, if poorly implemented, it can result in worse outcomes than a blame culture. Therefore, a just culture requires careful consideration and well thought-out implementation. This is not an easy task, because the impact of quality improvement techniques and isolated training programs on cultural change has been shown to be limited.

CHANGING CULTURE: WHAT CAN WE DO ABOUT IT?

Organizational culture cannot evolve sequentially, but requires a holistic approach. Without a fundamental change to the core values, norms, and expectations of the organization, change remains superficial and short-lived. Failed attempts to change may lead to cynicism, frustration, loss of trust, and deterioration in morale among members. It is only with the support of leadership and a human resources (HR) department that has the necessary institutional authority to implement consistent HR and professional practices that help shift general healthcare culture towards shared learning from incident analysis and just culture. In a practice environment with a just culture, all members of the healthcare team understand their ethical responsibility to call out defects, including their own, in the system of care without fear of retribution. In such a culture, healthcare professionals can feel at ease, safe in the knowledge that their mistakes will not necessarily lead to punishment but will always lead to systematic corrections and institutional improvements. **H**

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