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A Quarterly Column About Medical Ethics

Ethics, Quality, Safety, and a Just Culture: The Link Is Evident

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Despite the current challenges of healthcare reform, most would agree that quality in medicine will continue to advance. For example, our ability to accurately diagnose and treat complex and simple disease states has never been as advanced as it is today; this ability will continue to grow. At the same time, participation in the current healthcare system is becoming increasingly complex and therefore potentially even more dangerous to patients.

Not surprisingly, patient safety has emerged as a dominant theme in American medicine. Safety experts agree on the critical role that organizational culture plays in reliably preventing medical errors. Culture has been defined as "the way we do things around here." An effective safety culture is characterized by an environment in which frontline personnel are comfortable disclosing errors, including their own, without fear of repercussions. The "just culture" concept codifies this approach as a job performance expectation that maintains professional accountability. A just culture recognizes that individuals should not be held accountable for the failings of a care system that they do not control, and it maintains professional accountability by not tolerating reckless behavior, conscious disregard of clear risk to patients, or gross misconduct.

Innovations in medicine will present the medical community with new options for treating familiar conditions, at times offering opportunities for greater financial gain and reward. As innovations are adopted, variation in care delivery inevitably increases, leading to challenges in ensuring quality and affordability. Albeit with some delay, the medical profession develops and implements outcomes-based guidelines for treatment and diagnosis that are generally based on the ethical principles of beneficence, nonmalfeasance, respect for persons, and justice (responsible allocation of resources).

Healthcare providers are challenged daily with situations requiring decisions that balance patient safety with the ethical allocation of resources. Healthcare organizations are increasingly aware of opportunities to change processes and systems and to prevent avoidable harm. It seems that every year a new program is created to improve quality and safety. A new administrator is hired or advanced, and a new medical director is given a title to allow for the advancement of care improvement in the healthcare organization. For individual members of the healthcare team, these activities can quickly result in initiative fatigue. But in the end, one should remember that, as healthcare providers, we are only being asked to always do the right thing, at the right time, to the right person. We are asked to place the patient above everyone, everything, and every strategy. Basically, ethical consideration in all activities within the healthcare setting is demanded.

The science of safety, based on work in other industries that involve high-risk situations, is now being applied to medicine. Diligent process reviews to discover variation and prevent defects are at the heart of this science. The ability of any member of the team to feel comfortable reporting any problem at any time is vital for continued success. Linking ethical behavior and decisionmaking to a quality and safety program with a just culture as its most basic component is only logical.[1] 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. The organizational ethic is reviewed and controlled by systemwide committees that often spend hours

reviewing policies and behaviors surrounding life and death issues. The movement to a just culture applies this type of thinking to everyday healthcare activity.

For example, what are the ethical and safety connections of the implementation of the universal time out, wherein all members of the team about to perform a procedure stop all activity to mindfully double-check the patient's identity, the procedure to be performed, the key items needed, and any special considerations affecting safe performance? No moral or ethically correct provider would ever want to perform a procedure on the wrong patient or on the wrong side of the body or to perform the wrong procedure altogether. Yet we continue to see examples of improper time-out practices. In the past year, improper time outs have occurred several times even in our own organization. The physician, nurse, technician, and everyone else involved in patient care failed to do the right thing. Safety, quality, medical legal risk, and ethics were all compromised in one fleeting moment that could have prevented the harm and hardship that befell the patients affected by these lapses. We argue that such events will continue until we collectively achieve a culture of safety and a just culture in our practice settings and organizations. A safe environment for patients requires a culture that allows for the safety of those reporting practitioner lapses and system defects. An ethical organization will have a just culture encoded in its DNA.

Every member of the healthcare organization must participate to obtain accurate reporting of potential and actual defects in the delivery system. In safety science, these reports of defective processes—whether or not actual harm did result or could have resulted—are considered essential to the improvement of care systems to achieve a safer patient environment. Hierarchy in healthcare is built into the training and privileging system and will always exist. High-risk industries such as air transportation have identified the authority gradient that results from such hierarchies as a key problem. Establishment of a just culture can improve safety because it clearly demonstrates that speaking up to identify a potential safety hazard or defect is expected of every member of the healthcare team. Some organizations, including ours, have gone as far as using policy to anchor a just culture, but more important is how the spirit of a just culture is practiced every day. In a just culture, the physician is viewed as a member of a team with the same ethical responsibility to provide safe care in an environment that is also psychologically safe for team members.[2] The just culture in medicine breaks down the authority gradients and hierarchal barriers that remain prevalent in many practice settings. An ethically correct culture allows for the right behavior toward the patient as well as the individuals involved in the care of that patient.

Ethics is about making the right decisions and implementing policies that are fair and just. Ethical thinking protects those who cannot protect themselves. Safety and quality strategies have the same objective. Their successful implementation requires a just culture at their core to protect the entire healthcare team in the reporting of unsafe conditions and behaviors. The connection is pure and simple: Ethics, quality, safety, and a just culture all involve doing the right thing at the right time to the right individual.

REFERENCES

1. Dekker S. *Just Culture: Balancing Safety and Accountability*. Burlington, VT: Ashgate Publishing; 2008.
2. Edmondson AC. *Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy*. Hoboken, NJ; Jossey-Bass; 2012.