An Opportunity for Osteopathic Medical Education to Create Change in Healthcare:

What is Collaborative “Just Culture?”

Presented by Scott Griffith

Founding Partner and Principal Collaborator
SG Collaborative Solutions

Friday Plenary Session
Participants should be able to:

• Recognize and guard against the Outcome Bias

• Describe a balanced accountability in terms of both systems and human behaviors within the socio-technical pyramid of risk

• Understand the fundamental attributes and advantages of a Collaborative Just Culture™

• Articulate the key concepts of collaboration necessary to produce better learning and clinical outcomes through osteopathic education
It’s in Our DNA…

Frans de Waal, Ph.D.
Professor of Psychology
Emory University
“All too often...we enjoy the comfort of opinion without the discomfort of thought.”

John F. Kennedy
How Do We Manage Risk Today?
How Do We Manage Risk Today?

- Do we generally punish behavior associated with adverse outcomes?
- Does the level of harm often determine our response to the team member?
- Are we biased toward responding to the physician or employee rather than examining our systems?
- Are we reluctant to hold people accountable?
- Are we reactive or proactive?
A Recent Case Study

Nina Pham is the nurse who contracted the Ebola virus at Texas Health Presbyterian Hospital Dallas.

Pham was the first patient to contract the disease while on U.S. soil, according to the Centers for Disease Control and Prevention, which said the transmission resulted from an unknown “breach of protocol” in treating Thomas Eric Duncan when he returned to Texas Presbyterian a second time.

On Monday CDC director Tom Frieden clarified that he in “no way meant to place blame on the stricken nurse.”

Source: NBC News
A Recent Case Study

The CDC “blasted for 'scapegoating' infected Texas nurse for 'breach in protocol' while treating Dallas patient - as experts say US medics are unprepared for outbreak”

Source: The Daily Mail
Where We’ve Been in Healthcare

“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes”

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on Health Care Quality Improvement
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 OR has a policy that says new equipment will be officially approved and training will be conducted prior to its use. None of the OR staff spoke up when they saw that the physician was about to use equipment that had not been approved.
The Outcome Bias

Surgeon Use of Unapproved Equipment – Harmful Outcome

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<th>Take No Action</th>
<th>Warn Not to Make Mistake</th>
<th>Encourage Different Behavior</th>
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## The Outcome Bias

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A Brief Introduction to Predictive Risk Management
Simple Models Are Seductive…
...and Sometimes Wrong
Risk Identification and Ranking

First, a Risk Register

👩‍💼 A ranking of the causes of harm by type of event

💡 Classified by likelihood, severity, and time criticality
Causal Mapping and Intervention

Socio-Technical Probabilistic Assessments by Category of Adverse Events

Then, an Explanation
- A description of how the events can occur
- Quantitative set of possible paths
- Linkages between errors, behaviors, equipment failures
Comparison with Known Events

Third, Event Data

- Events as opportunities to inform the risk model
- Events to let us know how the model is working

Develop Your Strategy and a Dashboard of Predictive Management of Risk
The Socio-Technical Pyramid of Risk

- Adverse Events
- Near Misses

The Technical System

System Design

Human Behaviors

The Socio System

Learning Systems

Just Culture

Values

Culture
What Is A System?

The organizational support structures and controls we place around physicians and employees in the performance of their jobs.
A System Can Include…

- Policy
- Processes
- Equipment
- Software
- Training
- Maintenance
- Information
- Monitoring
- Resources
System Reliability

Design for system reliability…

- **Barriers** - to prevent failure
- **Recovery** - to capture failures before they become critical
- **Redundancy** - to limit the effects of failure
- **Human factors** - to reduce the rate of error

… Systems can be predicted to fail and managed accordingly
Human Reliability

Performance Shaping Factors:
Influences that shape the outcomes we produce through our actions

... knowing that humans will never be perfect, team members can be predicted to fail and their behaviors managed accordingly
Performance Shaping Factors

Examples of System Factors:
- Training
- Environment
- Distractions
- Stress
- Fatigue
- Policy, process, or procedure
- Equipment malfunction
- Equipment/human interface

Examples of Personal Factors:
- Health issues
- Personal conflicts
- Distractions
- Stress
- Fatigue
- Past experiences
Human Behaviors
Three Categories of Behavior

**Human Error**

The inadvertent action; inadvertently doing other than what should have been done (i.e., a cognitive or physical slip, lapse, or mistake)

**At-Risk Choice**

Behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified (action chosen without intention to cause unjustifiable harm)

**Reckless Choice**

Behavioral choice to consciously disregard a substantial and unjustifiable risk (action chosen without intention to cause unjustifiable harm)
Two More Categories of Behavior

**Impossibility**

The risk mitigation strategy (i.e., the policy, procedure, or process was outdated, wrong, or impossible under the circumstances)

**Justifiable**

Having sufficient grounds for the behavior (i.e., the value chosen superseded the required action)
Two More Higher Culpable Behaviors

**Knowingly Causing Unjustifiable Harm**

A choice where unjustifiable harm is practically certain to occur

**Purpose to Cause Unjustifiable Harm**

A choice where the purpose of the behavior is to cause unjustifiable harm
To Err Is Human
To Drift Is Human
At-Risk Behavior

A behavioral choice that increases risk without perceiving the risk (i.e., unintentional risk taking), or is mistakenly believed to be justified

We are driven by our perception of the consequences

- Immediate and certain consequences are strong
- Delayed and uncertain consequences are weak
- Rules are generally weak
A Reliable Tool to Manage Socio-Technical Risk
The Collaborative Just Culture™
Systems and Behaviors
Response Guide©
The Collaborative Review Team

**Roles and Responsibilities**

**Physician / Clinical Leader**
- Manages Systems and Behaviors

**Risk/Quality/Safety Officer**
- Facilitates and guides the review process
- Procures additional expertise for the review
- Documents and reports findings and recommendations

**HR or Physician Staff Professional**
- Ensures workplace fairness
- Monitors culture and team member relations

**Optimized Viewpoint**
Performance Shaping Factors on the Physician
(The strong influences on Human Behavior)

Cultural
System

Perception of Risk of Harm

Personal

Perception of Risk of Artificial Danger

The Physician

At-Risk Behavior
What role will Osteopathic Medical Education play in determining our healthcare outcomes?
Please join us in the 9:45 AM - 10:45 AM breakout session:

Integration of Collaborative "Just Culture" in Osteopathic Medical Education
Thank You!

Please visit us at:

www.sg-collaborative.com