

Marquette University

e-Publications@Marquette

---

College of Nursing Faculty Research and  
Publications

Nursing, College of

---

7-2003

## Blame--Do You Know It When You See It?

Patricia R. Ebright  
*Graduate Programs*

Kathryn Rapala  
*Marquette University, [kathryn.rapala@marquette.edu](mailto:kathryn.rapala@marquette.edu)*

Follow this and additional works at: [https://epublications.marquette.edu/nursing\\_fac](https://epublications.marquette.edu/nursing_fac)



Part of the [Nursing Commons](#)

---

### Recommended Citation

Ebright, Patricia R. and Rapala, Kathryn, "Blame--Do You Know It When You See It?" (2003). *College of Nursing Faculty Research and Publications*. 797.  
[https://epublications.marquette.edu/nursing\\_fac/797](https://epublications.marquette.edu/nursing_fac/797)

Marquette University

e-Publications@Marquette

### ***Nursing Faculty Research and Publications/College of Nursing***

***This paper is NOT THE PUBLISHED VERSION; but the author's final, peer-reviewed manuscript.*** The published version may be accessed by following the link in the citation below.

*Outcomes Management*, Vol. 7, No. 3 (July/September 2003): 91-93. [PubMed link](#). This article is © Lippincott Williams & Wilkins, Inc. and permission has been granted for this version to appear in [e-Publications@Marquette](#). Lippincott Williams & Wilkins, Inc. does not grant permission for this article to be further copied/distributed or hosted elsewhere without express permission from Lippincott Williams & Wilkins, Inc.

## Blame-Do You Know It When You See It?

Patricia Ebright

Assistant Professor, Indiana University School of Nursing, Indianapolis, Ind.

Kathryn Rapala

Director, Risk Management and Patient Safety, Clarian Health Partners, Indianapolis, Ind.

The landmark Institute of Medicine Report, *To Err Is Human: Building a Safer Health Care System*, stated that medical error causes 44,000 to 98,000 deaths per year. 1 There is no question that the report raised awareness of patient safety and stressed the importance of patient outcomes. Heightened awareness has produced a patient safety industry of sorts, with solutions that range from technology to outcomes measurement.

Regulatory bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), have recognized the need for patient safety to be embedded in the culture of healthcare organizations. In particular, the JCAHO has encouraged use of the root cause analysis process for investigating near miss and adverse events. This process emphasizes learning from system analysis over assigning individual blame, an approach used successfully in such high reliability organizations as the aviation industry and the military. 2,3 Many healthcare organizations have formulated nonpunitive reporting policies to encourage error reporting and to identify systems issues. This article discusses the importance of a work complexity and human factors focus, how blame will

continue to surface as patient safety efforts are implemented, and implications for outcomes management.

## Removing Blame

Although policies, organizational assessments, and regulations are an important starting point for best practice, these steps are neither sufficient to ensure changes in attitudes and behaviors related to human error nor adequate to deal with the implications of human factors inherent in real work situations. Even when an organization chooses to move beyond policies and truly embrace a change in culture, blame is not easily eliminated. Understanding the complexity of real work and the limits of human performance is essential to establishing and maintaining a nonpunitive culture and, subsequently, positive patient outcomes.

## Human Performance and Complexity of Work

Understanding a near miss or adverse event, as well as the human decisions and performance that preceded it, requires understanding of the context or the situation surrounding the event. Near misses and errors occur when multiple gaps align despite an organization's well-intentioned defenses. Examples of the latter include policies, procedures, regulations, and budget. Practitioners work in dynamic, evolving situations, confronted by goal conflicts, obstacles, hazards, missing or ambiguous information, and co-worker behavior. 4 In most instances, practitioners practice successfully by adapting, anticipating, accommodating, reacting, and coping to produce desired and safe outcomes.

A fundamental principle of human factors is that humans have limitations. Essential to any event review is the recognition that the complexity surrounding the situation is a contributor to an adverse event. It is important not to dismiss complexity by implying that practitioners can do things a certain way even if overwhelmed in any situation. In complex work situations, a predictable pattern of breakdown of human performance may include fixation failure, which is the failure to adapt or revise because of the diversion of attention and/or missing knowledge. Another predictable pattern is over-reliance on familiar signs. 5 Some clinical work can become so ordinary that automatic behaviors lead to unintended slips resulting in error.

What practitioners do with a great deal of accuracy in unpredictable and rapidly changing situations is to adapt and reprioritize continuously. Given new cues or information, trade-offs are made by practitioners to achieve best outcomes. For a practitioner with an overwhelming workload, predictable adaptations include trading accuracy for speed, reducing performance criteria, shedding and/or deferring tasks, and recruiting resources from other personnel.

Unpredictability, time pressures, ambiguity, and stress are characteristics common to the healthcare environment. Understanding this complex environment is important so that systems are designed to support practitioners in their work. Blaming individuals after near-miss and adverse events precludes and often replaces the search for understanding of the complexity surrounding situations. Successful change from a blame culture to a nonblame culture may be gained by analyzing some of the more subtle organizational signs that indicate further attention is needed.

## Subtle Signs of Blame

By now, most practitioners and organizations recognize that it does not solve a systems problem to fire or discipline the staff person who made the error. However, blame can lurk in some identifiable behavior patterns. Rather than blame an individual directly, these subtle signs of blame

still focus on individual behavior, do not address the systems issues, and accordingly do not produce positive and lasting patient outcomes. Following are some identifiable subtle signs of blame.

#### Conclusion: Human Error

Root cause analyses are meant to address systems issues. It is tempting to conclude after a review that human error was the culprit. The contributors that preceded the end point of human error are the factors that will lead eventually to a future event. When human error is the conclusion, nothing is proposed as needing further attention. Work complexity issues are not addressed. Not only does focusing on human error as the conclusion reflect blame of individuals for failure, it also precludes learning about how a similar event may be prevented in the future.

#### Obvious Error: Lazy Review

It is tempting to exclude certain errors or near misses from review because it is "obvious" what caused the event. This tendency to jump to conclusions illustrates the concept of hindsight bias. Hindsight bias is the tendency to simplify the sequence of events after the fact. Although the human tendency toward hindsight bias is apparent in every organization, increased awareness before and during every review to prevent assignment of blame is crucial for learning. Accepting the "obvious" conclusion as the final interpretation of an event misses the opportunity to understand the event and improve the system and outcome.

#### Silo Review

A variation of hindsight bias is the silo review. Individual disciplines may understand the complexity of their own work and apply nonblame approaches to learn from error. However, because a practitioner may not understand the work of other disciplines in the same way, the tendency is to resort to simplistic assumptions about work complexity in relation to other disciplines.

#### Failure to Transfer Knowledge

As an organization develops a culture of safety, some staff will apply the knowledge gained from understanding work complexity to a specific patient safety initiative and implement system changes successfully. However, the same staff may not transfer the principles of nonblame and work complexity to the next patient safety situation. To the staff member, a different patient safety issue may seem unrelated to the last project such that the underlying work complexity framework is not applied.

#### Using New Language to Perpetuate Old Beliefs

The patient safety movement has a language. Although staff may learn patient safety terms and theories, some try to use the new language to fit old behaviors. For example, the "Swiss cheese model" adapted from Reason 7 is a valuable and commonly used representation to explain failure in complex systems. In this model, the gaps, illustrated by the holes in the slices of Swiss cheese, line up and result in an error. The slices illustrate different organizational points of defense or operations such as staffing guidelines or the process for product purchasing decisions. When reviewing an event, a staff member familiar with the Swiss cheese model may list multiple individuals as the points of breakdown or gaps in the system rather than actual systems issues.

#### Re-education

When reviewing an event, one of the easiest fixes is to re-educate staff regarding a process. This should not be the only improvement strategy done after a patient event for two reasons. First, re-education regarding a policy or process assumes that the policy or process is correct. Second, re-education obliquely implies that if the staff member had followed the policy properly, the event

would not have occurred. Without a work complexity analysis in relation to the patient event, both assumptions are most likely incorrect.

### Tighten up the Policy

Another popular way to address a systems issue is to "strengthen" an existing policy. Policies and procedures are a necessary part of patient care. Policies are most effective when they take into account work complexity and incorporate flexibility. Adding steps to a policy that do not reflect the way work is performed will not necessarily reduce the likelihood of future similar errors.

## Implications for Outcomes Management

Implementation of best practices, new procedures, new technology, and/or policies is dependent on how well the change fits within the context of the real work of practitioners. Once change is implemented, evaluation of whether the achievement of outcomes was successful, partially successful, or a failure requires understanding of practitioner work in the context of real situations. Next steps in the failed implementation of a change may have nothing to do with re-education but more to do with how to support practitioners in dealing with the work change as a result of the new process.

Learning about real work and achieving outcomes can be generated through reviews of near-miss and adverse events when the focus of reviews is on systems, not individuals. Subtle signs of blame may continue despite ongoing education regarding patient safety; recognition of subtle signs of blame reflects self-awareness as an organization moves toward high patient safety reliability. Organizational interventions should include ongoing reinforcement of rationale for nonblame approaches and facilitation of focused system reviews after near-miss and adverse events. Most importantly, understanding the real work environment is essential before any change is implemented.

## References

1. Kohn L, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. Institute of Medicine. Washington, DC: National Academy Press; 1999.
2. Cook RI, Woods DD, Miller C. *A Tale of Two Stories: Contrasting Views of Patient Safety*. (Report from a workshop on assembling the scientific basis for progress on patient safety. Available at: <http://www.npsf.org>.) Chicago: National Patient Safety Foundation; 1998.
3. Roberts KH, ed. *New Challenges to Understanding Organizations*. New York: MacMillan; 1993.
4. Woods DD, Johannesen LJ, Cook RI, Sarter NB. *Behind Human Error: Cognitive Systems, Computers, and Hindsight*. Dayton OH: Human Systems Ergonomic Information and Analysis Center; 1994.
5. Woods DD, Patterson ES. How unexpected events produce an escalation of cognitive and coordinative demands. In: Hancock PA, Desmond PA, eds. *Stress Workload and Fatigue*. Hillsdale, NJ: Lawrence Erlbaum; 2001:290-304.
6. Fischhoff B. Hindsight does not equal foresight: the effect of outcome knowledge on judgment under uncertainty. *J Exp Psych: Human Perc Perf*. 1975; 1:288-299.
7. Reason J. *Human Error*. Cambridge, UK: Cambridge University Press; 1990.