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Establishing a Safety Culture: Thinking Small

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Perspective

Safety cultures are the holy grail in any risky industry. Like all holy grails, they can never be fully realized. This is particularly the case in health care. Why? Health care organizations struggle with too many competing demands to make safety the only workplace priority (1), experience strong countervailing forces that undermine a strategic emphasis on safety (2), and have difficulty implementing abstract concepts like "high reliability" in clinical settings where work roles are often fragmented and compartmentalized.(3) Management and organization theory helps us understand these realities and offers us ideas for making sure "safety culture" ends up being more than a catchy phrase and a marketing hook. In this article, I apply management and organizational principles to examine the concept of safety culture and suggest steps for achieving one.

The Unfortunate Watering Down of a ConceptA few years ago, I set out to study residency and academic medical center safety cultures with respect to how young doctors were trained and socialized to deal with mistakes. As a health administrator, consultant, and researcher for 15 years, I had been both a student of and participant in medical practice culture. However, searching for and studying a *culture of safety* was an eye-opening experience, even for someone trained to see the socially constructed dynamics that typify any organizational workplace. A workplace rarely succumbs to the simplified assumptions social scientists impose on it for empirical purposes.

The experience and data (1,4) convinced me that we need to look at the concept of safety culture in medicine in a different way. In short, we need to discard our goal of achieving some idealized vision of a health care safety culture, and instead focus on making more practical, incremental progress. We need to act now, and study later, if at all. If we do, we have a better chance of making safety a routine part of the business of health care organizations.

This will not be easy. Researchers, managers, and policy makers have grown enamored with the abstract idea of the safety culture and less attentive to what can be done in the workplace, however small or incremental, to move organizational and professional cultures in the desired direction. All sorts of safety culture measurements and assessments now exist. We treat the concept as if it has universality in both

form and function across health care settings. We treat it holistically and distinctly, something to be developed in its entirety. Accreditation and awarding organizations come up with neat little checklists to quantify it for their reviews. For these reasons, the concept of safety culture is in danger of becoming mechanistic and rhetorical, and, as that happens, it loses some of its power to promote safe health care.

Normalizing Safety Cultures in Health Care Settings The field of organizational learning tells us the kinds of attitudes and behaviors that need to be in place for safety cultures to emerge. These attributes do not take a rocket scientist, nor years of examination, to understand. Self-reflection, empathy, inquiry, feedback, forgiveness, systems thinking, communication, and creative tension are examples of the attributes comprising any safety culture.(5-7) But they must be sought after with an understanding that their success is intertwined with and dependent upon, not separate from, the larger social and structural milieus of the organization and its environment.

For example, I believe that one cannot think about establishing a safety culture without understanding the realities of physician power and professional-organizational conflict in a given setting, the way in which the hospital or practice treats and pays its workers, the staffing ratios in a given department, and the necessity of achieving other daily goals besides a safe clinical environment. One must also take into account the budget of the organization, its desired mix of services, the pressures exerted on it from outside stakeholders, the kinds of patients it serves, and its history of prior decision making around safety and error. Only after appreciating these "facts on the ground" can one think about making the changes needed to establish a safety culture.

Applying principles from management science instructs us toward a more contingent, pragmatic, and action-oriented approach to the concept of safety culture. First and foremost, this science pushes us to view the organization as a collection of routines and taken-for-granted ways of doing things that dominate all decision making and behavior.(8,9) Second, management science frowns upon major "reengineering" of work processes, which usually generate futile attempts to create new routines that diverge greatly from widely accepted organizational practices. This futility occurs because organizations and their workers find comfort in their existing way of life and resist trying new behaviors, regardless of the problem or situation.(10) Aversion to risk also undermines any attempt to introduce new things, no matter what their logic or evidence base. Instead, new behaviors (and concomitant attitudes and cultural norms) are born and grow through small changes in the accepted, normal behaviors that workers engage in every day. The result is incremental change that sticks, as opposed to radical change that either fails to take hold or flickers out as the institutional focus moves onto some other priority.

The perspective of incremental change has merit in considering how to develop and maintain safety cultures in medicine. For example, my research in teaching hospitals revealed how little room, energy, or opportunity there was for incorporating dramatically new behaviors and routines around mistakes into the everyday work of residents. Although there was wide recognition of the need for new approaches to preventing errors, the pressures of turning residents into competent clinicians in a short period of time, the time constraints in physicians' workdays, the structure of attending-resident hierarchy, the complexity of the differential diagnostic process, and the need for residents to make some mistakes to learn necessitated a different way of looking at culture change within this setting.

This different way of looking at culture change leads us to inject new behaviors and practices into things that resident and attending physicians already accept as "normal"—things that contribute to the effectiveness of their everyday work. For example, I observed the use of a written document called "the list" by resident teams to structure dialogue around patients and provide a neat, concise way of organizing the daily work of patient care. I saw the opportunity to use that list to help raise safety-related questions about different patient conditions, present hypothetical scenarios about what could go wrong for a particular clinical situation, and focus the entire resident team on a single aspect of care and how that care was being provided. Even if it was done for only a few seconds in each of several patient situations in the course of a day, over time the collective attention would form a shared meaning system about the use of this list for enhancing patient safety. Within the comfort of using the list to accomplish other necessary things (such as keeping superiors informed and remembering what needed to be done with whom), the resident team could, over time, also use the list for safety-related concerns and learning, as a normal part of their workday (Table).

I think health organizations should focus less on trying to achieve an idealized and all-encompassing safety culture and more on taking actions in the workplace that begin to get the attitudes and behaviors that typify such a culture into place, even if this creates changes that are slow and unnoticeable at first. Doing this will require that we take what we have and find ways to tinker with it, in essence "growing" new culture that can be layered onto the old. This modest approach may frustrate those who see the dysfunctions of the health care workplace—for example, the mistrust and conflict that exist between nurses and doctors or the cultures of fear and competition that drive many clinical settings and academic environments—as critical barriers to the development of safety cultures. But I believe that incremental action toward culture change recognizes and accounts for those dysfunctions and, instead of trying to ignore them or spend time and energy removing them, takes advantage of what they can offer for greater attention to safety.

My research has convinced me that it is not terribly important to know that a safety culture exists within a hospital or medical practice, or to assemble an elaborate blueprint designed to move an organization to become more safety oriented. This is a noble goal and it looks great on paper, but I doubt that it is attainable. Instead, let's focus on using the everyday behaviors people are comfortable with, strategically aiming to get them to do little things that, when added together over time, produce the desired effects of enhanced attention to safety. In the end, we might produce more of the desired change because there is less resistance and fear from workers that their everyday worlds will be turned upside down.

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References

Back to Top

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Table

Back to Top

Incremental Change Leading to Permanent Culture Change: An Example Using the Residents' Daily Work List(Go to table citation in commentary)

The established behavior or routine	The incremental addition to the behavior/routine to grow new culture	The permanent culture change that results	Existing culture remains
Resident teams use a computer generated list that includes all patients on the service, their diagnoses, hospital location, key lab results, and updated condition—its purpose is to keep superiors updated and organize daily work efficiently.	Superiors (e.g., attending and senior resident physicians) ask junior residents to come up with a possible care-related mistake that one could conceivably make while caring for a sample of the patients on the list.	Junior residents see using the list to generate hypothetical error scenarios as an expected task from their superiors; superiors normalize discussion of error scenarios as an expected duty on part of junior resident.	Attending–resident hierarchy remains, and fear of "getting it wrong" still motivates junior resident to perform competently with respect to the error scenarios.