Framework for Just Culture: Rhode Island Board of Medical Licensure and Discipline

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ABSTRACT: The Rhode Island Board of Medical Licensure and Discipline (BMLD) is the regulatory body for physicians in Rhode Island, granting licenses and imposing disciplinary actions. The BMLD created a framework in the context of Just Culture to evaluate allegations of misconduct regarding physicians. This framework incorporates core concepts from Just Culture, in order to help determine if a physician is blameless or blameworthy regarding the underlying allegations and to help determine accountability to the individual physician or attribute to systems issues.

Fictionalized Case Vignettes

Case 1: A 48-year-old female was scheduled for elective left nephrectomy due to renal cell carcinoma. The attending urologist initiated the surgical procedure on the right side and skipped steps in the established hospital procedure for universal protocol. The assisting surgeon entered the room and immediately recognized the urologist was operating on the incorrect side after the incision was made. The incision was closed, and the correct procedure was then performed. The error was explained to the patient post-operatively and both incisions healed without incident. Three weeks later, the same urologist, while working at an outpatient ambulatory care center, performed a ureteroscopy on the left ureter for nephrolithiasis. There was no stone retrieved. After the procedure, pre-op images were reviewed, and the stone was located on the right side. A second wrong-site procedure had occurred in a short period of time.

Case 2: A 60-year-old female was evaluated at a local emergency department for new onset severe headache. After an appropriate history and physical were performed, a CT scan, with contrast, was ordered. The hospital system utilized an electronic health record that allowed multiple patient charts to be opened simultaneously. The CT was ordered and completed on the wrong patient. There were no adverse consequences to either patient, and the physician apologized for the error and self-reported the error using the hospital risk management system. Several other physicians, during this same time period, had made similar errors in the busy emergency department.

Background: Just Culture

The mission of the Rhode Island Board of Medical Licensure and Discipline (BMLD) is to protect the public through enforcement of standards for medical licensure and ongoing clinical competence.[1] Periodically, it is necessary for organizations to codify their decision-making process in order to better carry out their mission. In 2019, the BMLD undertook the process of creating a framework for investigating allegations of professional misconduct and any subsequent complaint-investigation outcomes.

Just Culture is a familiar concept utilized in many hospitals, health care[2] organizations and other industries.[3] Just Culture balances individual accountability (which may lead to blame) with the fact that people work in organizations that have systems that may cause or contribute to errors.[4]

Essential in any organization, whether in health care, aviation, or any industry, is to work in an environment free of fear. The fear of punitive actions against medical professionals may make it difficult for providers and organizations to disclose their mistakes, regardless of whether they result in negative consequences. This culture of fear continues to perpetuate medical errors and places patients' lives at risk.[5] By having an agreed-upon and clearly understood set of acceptable and unacceptable behaviors, implementation of Just Culture ensures public safety and prevention of subsequent health-care-related errors.[6]

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Just Culture can be approached in two ways. The most recognizable, and historically known, approach is identifying the individual that caused the error and having that individual be held accountable.[7] In contrast, a more nuanced approach is to identify what organizational systems were in place at the time of the error and holding the organization accountable for the medical error.[8] Both approaches rely on the underlying principle that the individual and/or the organization learns from the mistake.

When errors occur, it is a natural reaction to assign blame and determine culpability. However, a question then arises: How can one make sensible decisions about culpability without a law degree?[9] Who should be the judge and jury when doing a root-cause analysis of errors in health care settings? It is important to reflect on the larger role of state medical boards and why the medical boards exist. In the United States, we typically resolve disputes through courts and utilize our judicial system; yet, with the exception of malpractice lawsuits, this is not so with physicians or other licensed professionals.

Physicians, as with other professionals, have the privilege of self-regulation,[10] referring to the responsibility of other physicians to evaluate culpability and assign blame regarding allegations of misconduct. The privilege of self-regulation is part of an implicit social contract between the profession of medicine and society — in exchange for expectations of professional responsibility, altruistic service, and professional accountability.[11] State medical boards have the authority to enforce regulations regarding physicians and are the primary authority regulating physicians.[12] State medical boards operate within administrative law, as determined by each state. Physicians are also subject to external entities that regulate to a lesser extent, including federal agencies, and the ever-present specter of malpractice litigation.

Board members in Rhode Island are chosen because of their technical expertise and objectivity, and they serve without compensation of any type. This technical expertise allows them to evaluate physician competence and compliance with standards of care.

There are overarching approaches of Just Culture that can help distill decision-making about errors; these approaches have been designed to help guide Rhode Island's BMLD to make decisions about culpability:[13]

- ***Foresight Test:*** Did the individual knowingly engage in behavior that an average physician would recognize as being likely to increase the probability of making a safety-critical error?
- ***Substitution Test:*** Would another individual coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances?[14]

In Case 1, there are standard protocols in place at each hospital to prevent wrong-site procedures. These protocols include, but are not limited to, pre-operative assessment of a patient by all health care team members involved in the procedure, review of documentation and diagnostic imaging prior to the procedure, and time-out protocol. Per reports, the physician in question did not follow hospital protocol and failed to identify which site required treatment. Regarding Case 1, the physician failed the Foresight Test. In this situation, the physician failed to follow the hospital's Universal Protocol and therefore deviated from an agreed-upon protocol. This situation does not appear to reflect a systems issue; rather, it indicates an individual physician who should be held accountable for his or her actions.

THE PRIVILEGE OF SELF-REGULATION IS PART OF AN IMPLICIT SOCIAL CONTRACT BETWEEN THE PROFESSION OF MEDICINE AND SOCIETY — IN EXCHANGE FOR EXPECTATIONS OF PROFESSIONAL RESPONSIBILITY, ALTRUISTIC SERVICE, AND PROFESSIONAL ACCOUNTABILITY.

Case 2 describes an instance where a physician accidentally ordered the wrong test on a patient because the hospital systems in place did not have protocols on how to manage multiple patients' charts opened at the same time in their electronic medical record. The physician in question made the same error as several other physicians, self-reported the error, and apologized to the patient. The Substitution Test leads us to consider this as more of a systems error — requiring the hospital to improve its electronic health records with additional safeguards — than an individual error of the physician.

Framework

In pursuit of a Just Culture, and more appropriately differentiating between individual accountability and systems error, the Rhode Island Department of Health (RIDOH), in collaboration with its Center for

Healthcare Facilities Regulation (an agency within RIDOH that regulates licensed facilities in Rhode Island), adopted a framework for decision-making

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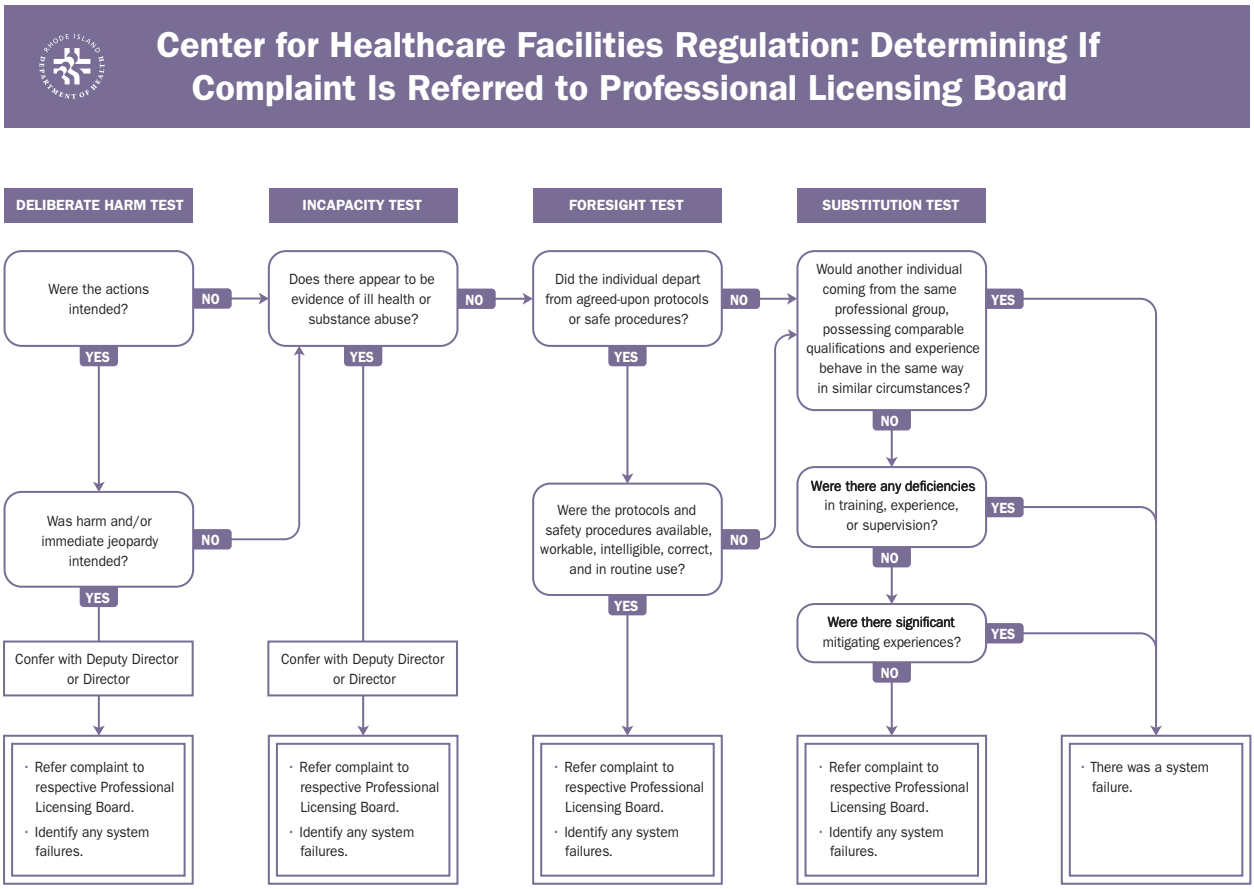
about *Determining if a Complaint is Referred to a Professional Licensing Board* (Figure 1). The BMLD also adopted a framework for decision-making about *Determining the Outcome of an Investigation of the Board of Medical Licensure and Discipline* (Figure 2).

Both frameworks utilize the Deliberate Harm Test, Incapacity Test, Foresight Test and Substitution Test to evaluate each new complaint, regardless of origin. These four tests are based on lessons learned from other industries that evaluate errors and mistakes in the context of safety and Just Culture.[15]

- ***Deliberate Harm Test:*** Was the action intended, and/or is there immediate harm/immediate jeopardy to the public? An action is intentional if the harmful result is purposeful or substantially certain to occur. It can be the result of action or inaction.
- ***Incapacity Test:*** Does there appear to be evidence of ill health or substance abuse?
- ***Foresight Test:*** Did the individual depart from agreed-upon protocols or safe procedures?
- ***Substitution Test:*** Would another individual, coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances?

Figure 1 illustrates the process RIDOH uses when receiving a complaint and deciding whether or not to refer it to a professional licensing board, such as the BMLD. It is important to consider if a complaint is referred to a professional licensing board. There are implications to a licensed professional regarding the stress of being investigated.

Figure 1



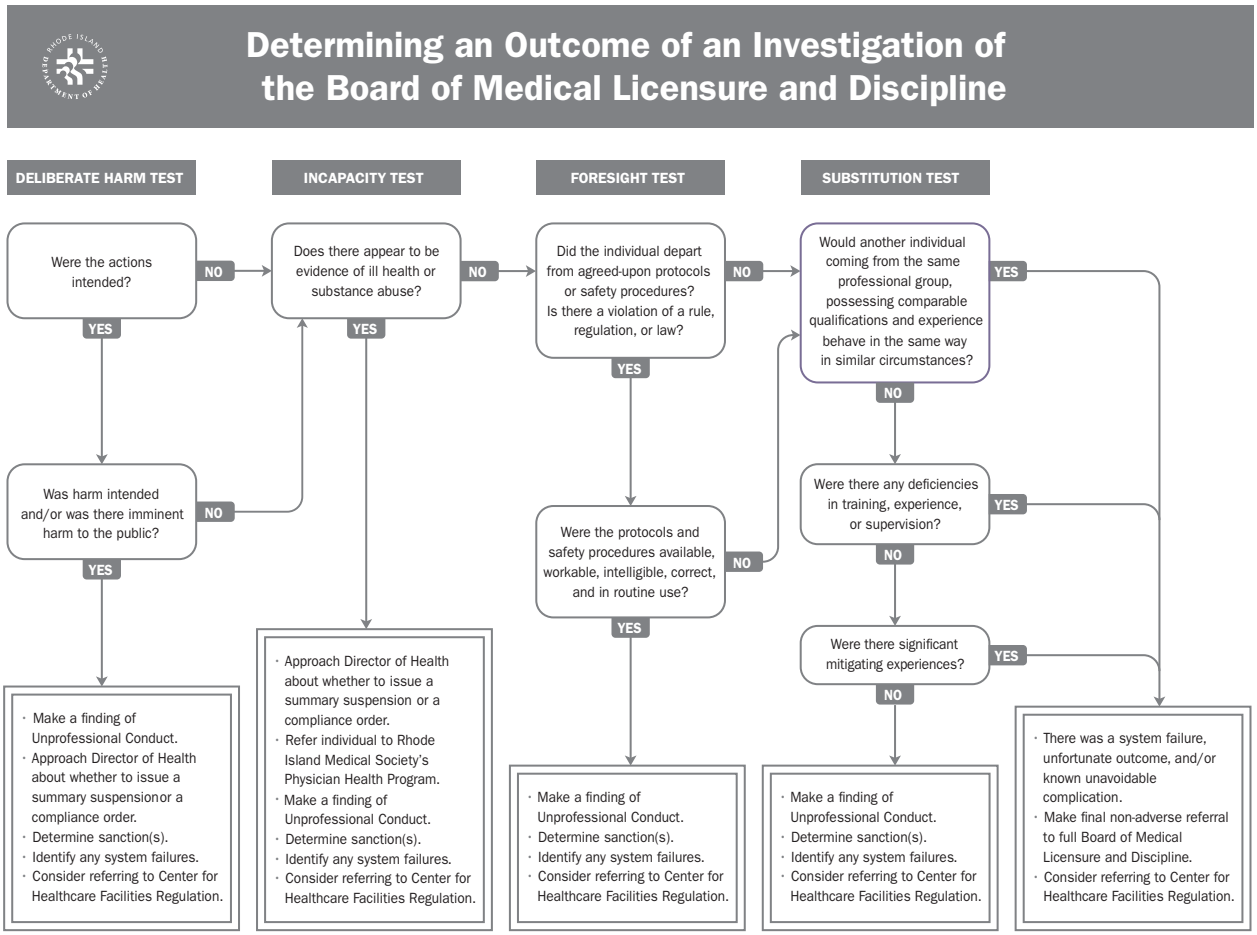
There are also implications regarding licensing boards, which have limited resources and must deploy them wisely.

A case is generally referred to a licensing board if the error involved a failure of the Deliberate Harm Test, Incapacity Test or the Foresight Test. However, there are circumstances where these matters could still be a result of systems issues/failures. Case 2 illustrates an error made by an individual physician, but clearly reflects a systems failure. Systems failures involve errors in a health care system and are not referred to a licensing board. Appropriately, the licensed facility must identify and address systems issues to prevent future errors. Adding safeguards to electronic health records and training users are examples of steps the licensed facility in Case 2 can take to prevent subsequent errors.

The actual process of implementing the framework described above occurs through scheduled weekly joint meetings inside RIDOH between The Center for Facility Regulation and the applicable professional board. These weekly joint meetings reinforce common understanding and facilitate cooperation inside RIDOH prior to formal investigation.

Figure 2 illustrates the process the BMLD uses when investigating a complaint and deciding whether or not an individual physician should be held accountable for their actions. This process also addresses the possibility of larger public health threats and whether the Director of Health needs to take immediate action to protect the public. In Case 1, the physician failed the Foresight Test, the hospital and ambulatory care facility had safe protocols and procedures, and the physician chose not to follow them. Additionally, since there were two similar cases in a short period of time, use of the Incapacity Test and Deliberate Harm Test need to be considered. Operating on the wrong side of a patient (wrong-site procedure) is often considered a "never" event[16] — representing a serious medical error that can have life-threatening consequences to the patient.

Figure 2



Conclusion

Through the framework adopted by RIDOH in 2019, RIDOH and the BMLD have established a transparent framework that reflects Just Culture. There is a purposeful balance to look at errors and differentiate between systems issues and individual errors. Systems issues may result in a physician being found blameless regarding a medical error; however, it is expected that the physician will actively participate in systemic improvements in his or her health care facility to prevent future errors. Although it is too short a time to quantify complaint metrics, the process has become embedded in the RIDOH culture and has permeated to other professional boards, including those regulating physician assistants and podiatry. Throughout the year of implementation, this new process has been applicable to all complaints as a useful framework for evaluation and planning, as well as facilitating ultimate decisions.

Individual errors may result in a physician being found blameworthy and held accountable via a disciplinary action. Disciplinary actions can include sanctions of license reprimand, monetary penalties, mandated continuing education, license suspension or license revocation. The BMLD considers all factors in every case it investigates and uses its collective wisdom and judgment to determine fair sanctions. The BMLD endeavors to be consistent with prior cases that are similar in nature as a further reflection of Just Culture.[17]

As regulators, hospitals, health care organizations and physicians, we all aspire to the same outcome of optimal, safe and reliable patient care. Patient safety is not a slogan; it is a purposeful outcome that has to be instilled in the organizational culture of any health care organization. Patient safety matters to all of us who enjoy the privilege of working in this profession, and it also matters to anyone who will, someday, be a patient in our health care marketplace. The framework described in this article applies to specific RIDOH professional boards and the Center for Facility Regulation, yet it is evident these concepts are applicable to any patient safety organization as it evaluates medical errors and endeavors to deliver safe, quality patient care in a Just Culture. ■

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