



# The Just Culture Community

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working together to improve  
organizational culture

## NEWS and VIEWS

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### The Criminal Edition

*We call this the "criminal edition." In recent months, a nurse and two pilots have found themselves on the receiving end of criminal indictments for mistakes they made in their professional work. These indictments have spawned considerable dialogue - much of it unhelpful. In a series of articles for this criminal edition, I have attempted to frame the problem. When does a criminal indictment support system safety? How does criminal behavior fit within the Just Culture model?*

*This issue is crucial to our journey to create strong, open safety cultures. We invite you to share this edition with anyone you choose. We also invite your feedback.*

**David Marx, JD**  
Editor in Chief

### Professionals Facing Criminal Charges – A Threat to System Safety?

Julie Thao was a nurse at Saint Mary's Medical Center in Madison, Wisconsin. On July 5, 2006, Julie was attending to a 16-year old woman in labor. The mother-to-be had a strep infection, leading the doctor to order penicillin to protect the baby from infection. As expressed in the criminal complaint, Julie Thao took a second medication out of the locked storage so that she could show the young, anxious patient what the actual medication would look like. Through a series of events, this second medication (Bupivacaine) was administered to the patient instead of the desired penicillin. Within 5 minutes of administering the Bupivacaine, the patient was in seizure, and soon dead. This event led the Wisconsin Department of Justice to file a criminal complaint against Julie Thao, that if found guilty, would be a class H felony, punishable by a fine not to exceed \$25,000 or imprisonment not to exceed 6 years, or both.

Approximately two months later, over the country of Brazil, two US pilots, Joseph Lepore and Jan Paladino, were involved in the worst aviation accident in Brazil's history. At 37,000 feet, their executive jet clipped the wing of a Gol Airlines 737, sending it

spinning out of control, killing all 154 people on board. Like the nurse in Wisconsin, the two pilots face criminal charges in Brazil for "a lack of necessary diligence that is expected and required of flight crews."

Both of these events have led to public debate. In Wisconsin, the hospital association issued a press release:

*"The Department of Justice's (DOJ) decision to pursue unprecedented criminal charges against a nurse who did not deliberately harm a patient accomplished nothing other than to compound the anguish of the situation... it makes no sense to add to this tragedy by alleging that this mistake, as upsetting as it was, was more than human error. And it is cruel to allege that this mistake constituted criminal conduct. By setting a precedent that the DOJ will pursue criminal charges against healthcare professionals who make unintentional human errors, the DOJ sends a chilling message to health care professionals now in the state, and to those considering practicing here."*

A November 20 editorial in the Madison *Capital Times*, stated:

*"While there is considerable pressure from the public and the legal system to blame and punish individuals who make fatal errors, filing criminal charges against a healthcare provider who is involved in a medication error is unquestionably egregious and may only serve to drive the reporting of errors underground."*

Likewise, in response to the criminal complaint following the aviation accident in Brazil, aviation safety experts have expressed regret. Flight Safety Foundation's Kenneth Quinn said:



*"There is a tremendous chilling effect that criminal prosecutions can have on getting people to come forward and admit mistakes. We need to focus not on putting people behind bars, but rather on finding out what went wrong and why, and then to prevent its reoccurrence."*

So how is it we got to this place, where safety experts and the criminal justice system are at odds as to the proper course of action? When did human error become a criminal act?

To trace the roots, we can look to *Morrisette v. United States*, 342 U.S. 246 (1952). In this case, now 55 years old, the Supreme Court of the United States traced the expansion of "criminal" actions into the realm of human error. While applicable only to US law, this historical path appears valid for industrialized society as a whole. In this case, Justice Jackson traced the roots of our criminal history regarding just who should be labeled a criminal.

*...our long history of criminal law provided that two elements be present – the "evil hand" and the "evil meaning mind." It is the combination of the "evil mind" and "evil hand" that has been the centerpiece of criminal law for centuries.*

Justice Jackson wrote that our long history of criminal law provided that two elements be present – the "evil hand" and the "evil meaning mind." It is the combination of the "evil mind" and "evil hand" that has been the centerpiece of criminal law for centuries. Ask anyone on the street to define the word "criminal" and you will find that necessary element of evil intent – an intent to cause harm. This is why many of us find the criminal indictments against Julie Thao, Joseph Lepore, and Jan Paladino to be unsettling. We do not believe these individuals had any "evil intent."

In that 1955 case, however, Justice Jackson went on to describe what has now put Julie Thao, Joseph Lepore, and Jan Paladino in jeopardy – an accelerating tendency to hold individuals responsible for behavior which leads to harm but which lacks any ingredient of intent or evil

crimes. Justice Jackson referred to these new crimes as "public welfare offenses." He spoke of the industrial revolution that exposed many more workers to increasingly powerful and complex mechanisms. He spoke of the advent of automobiles, where through our behaviors we could cause tremendous harm to one another. He spoke of the wide distribution of goods that would allow errors to propagate, and harm, at great distance. It is these industrial advances that caused legislatures in the early 1900s to pass laws that no longer required "evil intent" as a necessary element to be considered crimes. It was the birth of criminal negligence – or to put it in terms relevant to these two events, the birth of criminal human error.

The reality is that mere human error is now criminal in a number of circumstances where public safety is at issue. If our colleague or friend has been convicted of a "crime" we can no longer infer that they had "evil intent", but can instead only say that they breached an obligation that our lawmakers chose to call "criminal." For example, the Clean Water Act makes it a crime to inadvertently release pollutants into a river – regardless of the intent of the actor. Likewise, fathers and mothers who inadvertently leave their sleeping child in the car during the summer are brought up on criminal charges when that error has led to the death of the child. From a human factors perspective these events are statistically predictable events that randomly hit well meaning people – it is only a matter of who it is going to happen to. For whomever is unlucky enough to make one of these errors, criminal charges are only an indictment away.

Consider the recent case of Mary and Christopher Hansche, of Bossier City, Louisiana. They were sleeping on a mattress in the living room one evening when their six month old puppy began to gnaw on the toes of their one month old daughter who was sleeping beside them in an infant seat. The parents awoke to the sound of the baby crying – but only after the dog had chewed off a number of toes. The parents are in jail, charged with criminal negligence. Did Mary and Christopher have evil intent? Not likely. Are you and I, in our guts, happy to see the criminal charge? Probably yes. Our human nature is to react to the severity of the harm, the egregiousness of the injury. In our Just Culture model, we strive to keep the actual outcome out of our analysis, instead focusing on the quality of the choices of those involved. That being said, our guts still focus on the severity of the event.

We now live in a society where human error is not only against regulation, whether Federal Aviation Regulation or Nursing Practice Act, but is also increasingly becoming a criminal act, when that act has invaded the interest of public safety. Many observers have called the Wisconsin indictment “egregious” and objected to the “criminalization of unintentional errors.” Should we believe that the prosecutor overstepped his authority? Should we point the finger of blame (something we discourage in an open learning culture) on runaway lawyers? Or, should we look at what we have done through our elected officials, who over the last century have turned to the criminal law to protect the public against those who make mistakes. Should we look at the system - one that we designed – that makes human error a criminal act?



So what does the Just Culture model say about the actions of Julie Thao, Joseph Lepore, and Jan Paladino? Clearly, it appears that neither Julie, Joseph, nor Jan chose to cause harm. The harm was by mistake – to which our Just Culture would say to console. The Just Culture model sees the human errors and the resulting adverse events as outcomes, with the system design and the behavioral choices of those involved as the inputs.

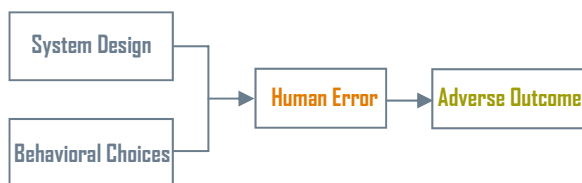
We must look to how the system design may have led to these events – that goes without saying to the safety professional. However, we must also look at the behavioral choices of those involved. We coach the at-risk behavior, and, yes, we punish the reckless behavior. Within the Just Culture model, in these two events we would turn away from the human errors and the severity of the outcomes to determine how Julie Thao, Joseph Lepore, and Jan Paladino should be held accountable. We would instead look to the quality of their choices. Did they make choices that put others at risk? Did they appreciate the risk associated with those decisions? Should Julie Thao, Joseph Lepore, or Jan Paladino be criminally prosecuted? I do not know. If we are prosecuting them because they caused significant harm, or were

the ones to make a human error – then our model says that criminal sanction will not be in the public interest as its deterrent effect on learning will far outweigh its impact on improving individual performance. If we are prosecuting these three because they took what they must have seen as substantial and unjustifiable risks, even though they did not intend to cause harm, then perhaps criminal charges are a reasonable and appropriate result. In the Just Culture model, it is the quality of one’s actions that dictates one’s accountability – not the inadvertent human error or the severity of its unfortunate outcome.

## Unintentional Human Error? Bad Language Indeed...

“The criminalization of unintentional human error.” That is what many observers called it. After all, there seems to be universal agreement that Julie Thao did not intend to harm her patient.

Shown below is a very simple anatomy of an adverse event that helps explain the contributions to a simple human error and its resulting adverse outcome.



A person makes a mistake that causes an adverse outcome. The person involved had no intention to cause the adverse outcome – that is why we call it a human error. The error is “unintentional” by definition. Behind the human error in this simple model is what we in the Just

Culture refer to as the two manageable inputs – the system we designed around this person, and their behavioral choices in that system. Consider the scenario where I inadvertently hit a car in another lane when I choose to change lanes on the freeway. The accident is caused by my human error – it is “unintentional” if you will. I did not intend to hit the other car. Behind my human error, however, are the system design and my behavioral choices. The system is what we know it to be – a standard freeway. What about my behavioral choices that might have contributed to the human error? If I were looking down dialing a cell phone when I made the lane change, would we still refer to the event as an “unintentional human error?” If I were intoxicated, would we still refer to the event as an “unintentional human error?” In each of these cases, while it would not have been my intent to cause the accident, it does seem disingenuous to refer to the entire event as an “unintentional human error” (particularly in the case of the intoxication or cell phone dialing) simply because I did not *choose* to hit the car next to me.

What the law has recognized for centuries, but is missed by many safety professionals today, is that humans carry with them two “intentions” relating to any specific action. There is the intention toward the action itself, and secondly, an intention toward the outcome of the chosen action. If I drive intoxicated, I do so by choice, but that does not mean I intend to cause harm to others. I intend the behavior, but I do not intend to harm.

In our Just Culture model we do not use the word “unintentional human error.” This term is not descriptive in that it does not separate the intention toward the action from the intention toward the outcome. Yes, Julie Thao did not likely intend to cause harm to her patient. That being said, it is not the end of the inquiry. What was her intent toward her actions, and what risks did she perceive to be associated with those actions? The Wisconsin Department of Justice called this event “more than a mistake,” citing a number of procedural violations where Julie Thao chose to deviate from required practice. Were they at-risk behaviors facilitated by the hospital? Were they reckless choices? This is where the Just Culture takes us.

Consider, Bob, the avid hunter trapped in the inner city. He has been cited by the police for illegally discharging his rifle within city limits. On Friday night, he hosts a party of fellow hunters. After some drinking, he brings his rifle onto his back porch to take a few shots at a target 20 yards away on his back fence. At one point a buddy says, “hey, look, a deer.” Bob turns to shoot an object behind his fence – but it is not a deer. It is a neighborhood child who he critically wounds.

## No Criminal Acts? What’s in a Policy?

Criminal. It’s a familiar term. We’ve been raised to believe that criminals are the “bad” people among us. We look at those being criminally prosecuted as having “evil intent.” As our principal article expressed, criminal law now no longer requires “evil intent.” Many criminal laws, and multitudes of federal and state regulations, make simple human error against the law.

Now look at most corporate human resource policies and safety reporting system policies and you will find an exclusion for “criminal acts.” That is, we will protect those who report human errors, but we will not offer the same for those who engage in criminal conduct. Seems reasonable. Commit a crime and we’re coming after you. Clearly, safety reporting systems were not meant to be a safe haven for criminals – or at least so we thought.

Such a policy statement - that criminal acts go well beyond the scope of intended safety reporting policies - would have had merit a few hundred years ago, before we enacted the “public welfare offenses” discussed by Justice Jackson. Criminal behavior today, irrespective of our commonly held beliefs about the “badness” of criminals,

Was it Bob’s intent to harm the child? No. Could we say then, that it was simply an “unintentional human error?” No. The notions of criminal law discussed earlier rightly provide that “evil intent” starts when one person consciously disregards a substantial and unjustifiable risk of harm to another. You need not intend harm – you need only to know the risk you are taking is unreasonable. Bob would fit that description and likely end up in jail – and rightly so. In the Just Culture model, we call his behavior “reckless.”

That is the question that should be applied to Julie Thao, Joseph Lepore, and Jan Paladino. Not whether they intended to harm. But rather, did they consciously disregard what they knew to be a substantial and unjustifiable risk to those around them? Ideally, that is the question that should be answered by the prosecutors before the charges are filed.

It is damaging to our notions of a Just Culture to suggest that Julie Thao should be absolved of societal responsibility simply because she did not choose to cause harm to her patient. This is not good safety science, nor does it align with either historical or modern versions of societal accountability.

covers a wide range of behaviors that in our model can include reckless behavior, at-risk behavior, and mere human error. The term “criminal” simply casts too wide a net today to make it a meaningful disciplinary policy provision in a safety reporting system.

Let’s say you nevertheless choose to spread the word that criminal conduct will simply not be tolerated. Again, this seems reasonable. Now, your environmental manager mistakenly dumps a chemical into the adjacent river. What you have done is to tell him not to raise his hand – the safety reporting system does not apply to him. He is a criminal, so pronounced by Congress’s Clean Water Act and reinforced by your internal prohibitions against criminal behavior.

There are other ways to identify the “evil conduct” that we cannot tolerate. The word “criminal”, in our modern world, is simply not one of them. The duties and breach expressed in the Just Culture model will cover the “bad” behavior you are trying to exclude. Merely tacking on “criminal acts” for good measure is not a good idea.

## The End of Regulation, the Beginning of Crime

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Julie Thao's event in Madison, Wisconsin raises an important question about when the regulatory framework (the Wisconsin Nursing Practice Act and the Wisconsin Board of Nursing) should be left to address the event, and when the broader criminal justice system should address the adverse event involving a nurse.

Those who go into the nursing profession unwittingly put themselves at risk. They are fallible human beings, destined to make mistakes along the way. And we also believe in the Just Culture model that human beings are destined to drift away from strict procedural compliance as perceptions of risk fade, and as they try to do more in a continually resource strapped profession.

So we create a regulatory structure, in part, to address those nurses who do not live up to their professional obligations. If a nurse cannot live up to the expectations of the profession, it is the task of the Nursing Board to take action in the public interest. This action may be to remove the nurse from practice, meeting the public objectives of deterrence within the profession and removing patients from the individual harm that a particular offending nurse might cause.

Given this, when should the criminal system come into play? When can the regulator of the profession not fulfill the demands of public expectation?

I do not think that healthcare professionals or aviators are served by claiming an exemption from the laws that govern the rest of us in society. Yes, they put themselves in harm's way, but so do firefighters, police officers, school bus drivers, and myriads of other professions. It is rather

a matter of when can the regulatory system meet the public interest so that criminal charges are not needed or warranted?

One possible path is to simply ask this question: Is the offending individual a threat to their profession, or a more general threat to society? A nurse who lacks competency as exhibited by repetitive human errors, might be best addressed through the regulatory process. A reckless physician who is unwilling to comply with site marking procedures in a hospital might also be best addressed through the regulatory scheme. In these scenarios, we might argue that restriction on or removal of the privilege to practice fulfills the societal obligation.

Compare these events to the physician who anesthetizes his patient, so that he can then rape the patient. Or the nurse who steals narcotics patches from patients to feed her own drug addiction. In these cases, you might decide that these two individuals represent a larger societal threat. Does removal from practice prevent further societal harm? Possibly not. In these cases, we might believe that the involvement of the criminal justice system will ensure that the risk that these individuals will cause further harm, whether at work or not, is minimized.

Particularly for those stakeholders who choose to revisit their enforcement schemes, the safety-supportive use of regulatory enforcement and criminal incarceration should be addressed. Where does criminal indictment of a regulated professional promote public welfare? Where does the regulatory framework end, and the criminal system begin?

## Epilogue - Back to the Dog

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OK, you probably cannot get your mind off of the dog that bit off the toes of the one month old child. How could reasonable parents let this happen? It makes my stomach churn. It is easy to think that criminal charges are being rightly brought against the mother and father.

That said, before we climb onto our pedestal to preach about bad parenting, particularly those of us who are dog owners, perhaps some statistics are in order:

- 👉 In the US alone, there are almost 5 million victims of dog bites annually -- about 2% of the entire population
- 👉 800,000 of these victims need medical attention
- 👉 1,000 per day need treatment in hospital emergency rooms
- 👉 Most of the victims who receive medical attention are children, half of whom are bitten in the face
- 👉 Most children are bitten by the family dog
- 👉 Dog bite losses exceed \$1 billion per year, with over \$300 million paid by insurance

So here's the question for those in the Just Culture Community. How would we explain to this little girl in Louisiana, five years from now, what happened to her when she was a newborn child? Would we say that she was the victim of a tremendous parenting mistake, and for that mistake, her parents are in prison and she is now in foster care? Alternatively, given the data shared above, would we explain that she was the predictable statistical result of a risk we were all willing to take? My local animal control facility will not allow adoption of black cats in the month before Halloween, in fear for the safety of the cat. That same facility will gladly give a dog to the willing family full of young children.

It is important to remember in our model of Just Culture that we as the system owners are not off the hook, even though much of our dialogue surrounds the individual actor. We find a fair and just path for the individuals involved in an event, we attempt to bring that learning to a system level, and then we are saddled with the resulting risks. Do we think that young girl in Louisiana would believe our system was adequately designed to protect her, given that 1000 people a day (mostly children) will visit emergency rooms to take care of a dog bite? I think not. For that, we also are accountable.

## December 2006 Public Course Success!

The Just Culture community is pleased to announce that the December 2006 Public Course was a huge success. With 115 attendees from as far away as New Zealand representing multiple industries from healthcare and aviation to railways and forestry, the participants were able to return to their organizations prepared to bring the Just Culture philosophies to life.

David Marx, President/CEO of Outcome Engineering and Scott Griffith, COO of Outcome Engineering were the primary speakers who laid the foundation by introducing Just Culture concepts for building open, fair, learning cultures. Dr. Rich Dinter, our Chief Medical Officer followed with a productive question and answer session. With his experience on the front lines of Just Culture implementation, Dr. Dinter was able to share both his expertise and experience.

We are excited about the growth of our community and the commitment of our members to lead their organization on the journey to becoming a Just Culture!



## Public Course

**April 17-18, 2007**

Our Just Culture course is the entry point for those seriously desiring to change their organizational culture through the use of Just Culture Community tools.

You will find that the course provides the foundation for how risk should be managed, both *before* and after the adverse event, and across all organizational values—not just safety.

Our experience shows that those who send a cross functional team will be best positioned to develop and nurture these concepts as they work together to lead their organization in its change process.

Please feel free to contact our office with any questions about our course.

The Just Culture Community  
972.618.3600

The course fee is **\$595** per initial attendee, and **\$495** for each additional person when registering two or more attendees from the same organization.

The price includes a one-year membership to the Just Culture Community

**Registration deadline is April 12, 2007**

### Course Topics

- Introduction to Just Culture
- Building a Safety Culture
- Building a Learning Culture
- Managing System Design
- Managing Behavior
- Event Investigation and Data Analysis
- Just Culture Algorithm
- Organizational Implementation