From a blame culture to a just culture in health care

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Background: A prevailing blame culture in health care has been suggested as a major source of an unacceptably high number of medical errors. A just culture has emerged as an imperative for improving the quality and safety of patient care. However, health care organizations are finding it hard to move from a culture of blame to a just culture.
Purpose: We argue that moving from a blame culture to a just culture requires a comprehensive understanding of organizational attributes or antecedents that cause blame or just cultures. Health care organizations need to build organizational capacity in the form of human resource (HR) management capabilities to achieve a just culture.
Methodology: This is a conceptual article. Health care management literature was reviewed with twin objectives: (a) to ascertain if a consistent pattern existed in organizational attributes that lead to either blame or just cultures and (2) to find out ways to reform a blame culture.
Conclusions: On the basis of the review of related literature, we conclude that (a) a blame culture is more likely to occur in health care organizations that rely predominantly on hierarchical, compliance-based functional management systems; (b) a just or learning culture is more likely to occur in health organizations that elicit greater employee involvement in decision making; and (c) human resource management capabilities play an important role in moving from a blame culture to a just culture.
Practice Implications: Organizational culture or human resource management practices play a critical role in the health care delivery process. Health care organizations need to develop a culture that harnesses the ideas and ingenuity of health care professional by employing a commitment-based management philosophy rather than strangling them by overregulating their behaviors using a control-based philosophy. They cannot simply wish away the deeply entrenched culture of blame nor can they outsource their way out of it. Health care organizations need to build internal human resource management capabilities to bring about the necessary changes in their culture and management systems and to become learning organizations.

The aim of this article is twofold. First, it identifies a set of organizational attributes that perpetuate a blame culture and those that foster a just culture in health care. Specifically, it explores if the blame culture is inherent in hierarchical, functional structures that are ubiquitous in health care organizations and if work systems based on greater involvement of health care employees or professionals promote a just culture.

Key words: blame culture, human resource capabilities, just safety culture, organizational learning, psychological safety

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Second, it proposes that human resource (HR) management capabilities play an important role in a health care organization's transition from a blame culture to a just culture. Developing the right culture at the clinical level is a complex and arduous task and may require organizational capacity in the form of HR capabilities, among other organizational capabilities, to accomplish it.

This article is organized into four broad sections. In the first section, we highlight the importance of organizational factors in health care delivery process along with identification of gaps in the current literature on patient safety. We then provide definitions of blame and just cultures. This is followed by a discussion of a set or pattern in organizational antecedents of blame and just cultures in health care organizations. In the last section, we suggest that HR capabilities are crucial in creating a just culture in health care organizations.

Importance of Organizational Factors in Health Care Delivery

We note three main gaps in the existing patient safety research related to organizational factors that this article specifically addresses: (a) lack of adequate research examining the role of cultural factors in affecting medical errors and quality of care; (b) lack of a comprehensive framework linking cultural factors to quality of care because initiatives undertaken to improve patient safety and quality of care tend to be piecemeal, having only a limited effect; and (c) although a good diagnosis or description of the factors contributing to medical errors now exists, there is a dearth of effective prescriptions to move from a blame culture to a just culture. We propose that the next frontier of research on patient safety is to make major advances in prescribing effective solutions by developing broad organizational capabilities and strategies for establishing just cultures. We elaborate on these purported contributions of the article in the following paragraphs.

Critical Role of Organizational and Cultural Factors in Patient Safety

"The need to implement effective healthcare *organizing* has become as pressing as the need to implement medical breakthroughs" (Ramanujam & Rousseau, 2006, p. 824). In fact, an emerging stream of research suggests that nontechnical medical errors are more prevalent than are technical errors in the health care delivery process (Catchpole et al., 2006; Khatri, Baveja, Boren, & Mammo, 2006; Lingard et al., 2002; Nembhard & Edmonson, 2006). For example, Catchpole et al. (2006) in their study of pediatric cardiac surgeries found that errors related to cultural and organizational failures were the most frequently encountered single type of threat to clinical quality. Similarly, Khatri, Baveja, et al. (2006) noted that about two thirds or more of all medical errors were related to nontechnical cultural factors. Nembhard and Edmondson (2006) reported that 70% to 80% of medical errors had nothing to do with technical factors but were related to interactions within the health care team, and Lingard et al. (2002) found numerous errors related to interpersonal rather than technical aspects of the operating room's functioning.

Despite the importance of organizational issues in medical errors, most health care institutions do not seem to think "organizationally" (Ramanujam & Rousseau, 2006). The prevailing notion within health care organizations is that caregivers act as they do because of personal motives and skills and that the organization or management plays little or no role in either caregiver behavior or patient outcomes (Khatri, Baveja, et al., 2006; Ramanujam & Rousseau, 2006). Consequently, most health care management interventions are isolated, dealing with specific clinical and operational settings, and fail to utilize organizational practices of known effectiveness, from socialization, coordination, and communication to leadership development and organizational learning (Edworthy, Hignett, Hellier, & Stubbs, 2006).

A prevailing blame culture in health care has been suggested as a major factor for an unacceptably high number of medical errors (Cook, Guttmannova, & Joyner, 2004; Institute of Medicine [IOM], 2001). A just culture has emerged as an imperative for improving the quality and safety of patient care (Pronovost et al., 2003; Sorra & Nieva, 2004). Research studies showed that employing quality improvement techniques and isolated training programs has limited ability to promote a just culture throughout the health care enterprise (Cook et al., 2004; IOM, 2001; Pronovost et al., 2003). This article explores a set of organizational attributes that perpetuate a culture of blame and also those that are necessary for instituting a just culture. An understanding of the attributes of blame and just cultures would enable health care organizations to develop a comprehensive intervention strategy to implement a just culture (Scott-Cawiezell et al., 2006).

Need for a Comprehensive Framework

An IOM (2004) report suggests that piecemeal approaches to patient safety will not be successful; rather, bundles of changes are needed if we want to take patient safety seriously. Similar sentiment has been expressed by other scholars. For example, Frankel, Gandhi, and Bates (2003) noted that combined tools that address cultural change and leadership and specific components of care delivery would be most successful. Etchells, O'Neill, and Bernstein (2003) recommended that the commitment

to improve patient safety should be demonstrated by the entire health care delivery organization led by senior management. Fogarty and McKeon (2006) argued that the deficiencies at the organizational level affect the psychological well-being of hospital employees, and distressed employees are more likely to engage in substandard work practices that ultimately endanger patients under their care.

The current models on safety climate or culture are circular in that they do not articulate any explanatory mechanisms between safety culture or climate and safety behaviors (Flin, 2007; Khatri, Halbesleben, Petroski, & Meyer, 2007). In general, there is a lack of theoretical specificity about how perceptions of safety climate in health care are actually related to worker safety behaviors and patient and worker safety outcomes. The competing value framework, a commonly used framework in previous research, has limitations. For example, Meterko, Mohr, and Young (2004) and Scott, Vojir, Jones, and Moore (2005) did not find a clear pattern of four cultures as theorized in the model. In fact, Meterko et al. ended up comparing only two of the four cultural types—teamwork and bureaucratic, which are quite similar to the two alternative management approaches of control-based and commitment-based management proposed by Khatri, Baveja, et al. (2006) that form the basis of this article. The two types of management approaches suggested by Khatri et al. nicely juxtaposed on two types of cultures—culture of blame and culture of safety. Further strength of the model of Khatri et al. is that it articulates explicitly the causal chain linking management approach to clinical outcomes via affecting employee behaviors, as shown in Figure 1.

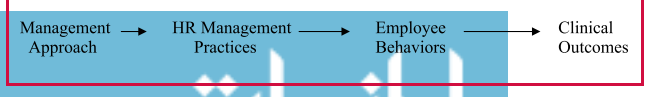
Urgency for Effective Prescriptions

The improvement in patient safety requires dramatic shifts in traditional organizational cultures because the prevalent culture of blame has been suggested as a necessary precursor of so many safety problems (IOM, 2001; Khatri et al., 2007; Schutz, Counte, & Meurer, 2007). Although some progress has been made in fostering safe cultures in isolated clinical settings, there is a long way to go until a culture of safety is the norm throughout the health care institution (IOM, 2004; Stryer, 2004). The development of a safety culture has been suggested to be "piecemeal," "spotty," and "too slow" (Etchells et al., 2003; Pace, 2007). Farley et al. (2009), in their recent study of adverse-event-reporting practices in U.S. hospitals, concluded that the blame culture is the norm in majority of the hospitals. Specifically, they reported that only 32% of hospitals have established environments that support reporting, only 13% have broad staff involvement in reporting adverse events, and only 21% of the hospitals fully distribute and consider summary reports on identified events.

Despite considerable effort devoted to medical errors since the publication of the IOM reports, most of the articles in the literature still largely describe the problem rather than present effective solutions (Stryer, 2004; Kirk, 2005). In general, many good descriptions of factors contributing to medical errors now exist (Flin, 2007). Health care managers and practitioners do recognize the need for moving from a culture of blame to a culture of safety, but the real challenge facing them has been to implement such cultures (Flin, 2007; Stryer, 2004). Bagnara and Tartaglia (2007) identified three important areas for patient safety research: work design, HR management, and cultural and organizational change. We think that the next frontier of the safety research is to make major advances in how to transform the traditional health care cultures. To succeed, we propose that an organization has to build capacity in the form of HR capabilities, among other organizational capabilities (Hammer, 2007; Khatri, 2006). HR capabilities would enable an organization to move from a blame culture to a just culture via enabling successful implementation of an appropriate regimen of HR practices (Khatri, 2006; Khatri, Baveja, et al., 2006). The current HR practices in health care organizations involve traditional "personnel management" that are far removed from the quality improvement interventions in health care delivery process.

Figure 1

The causal chain from management approach to clinical outcomes



Definitions of Blame and Just Cultures

Blame Culture

A culture of blame is a set of norms and attitudes within an organization characterized by an unwillingness to take risks or accept responsibility for mistakes because of a fear of criticism or management admonishment. This culture cultivates distrust and fear, and people blame each other to avoid being reprimanded or put down, resulting in no new ideas or personal initiative because people do not want to risk being wrong. It needs to be noted here that an organization does not purposefully choose a blame culture, but rather, such a culture evolves out of a bureaucratic management style that is highly rule-oriented,

compliance-driven, and focused on assigning blame or accountability to individuals even for system-level failures.

There are few things more demoralizing than a blame culture. It forces people to protect themselves by unnecessary paperwork, currying favor, or shifting blame—taking attention away from the patient care and hindering continuous improvement. Whereas individuals who are usually good at "office politics" thrive in such a culture, honest and hardworking individuals feel helpless and frustrated.

Silence is the predominant response in health care organizations to performance problems, near misses, or other deviations from desired practices, particularly when the actor responsible for the error is from a high-status professional group (Detert & Edmondson, 2007; Nembhard & Edmondson, 2006; Ramanujam & Rousseau, 2006; Tangirala & Ramanujam, 2008). For example, medical residents are reluctant to question senior physicians, and nurses hesitate to directly challenge a physician's medication order they believe as incorrect. Employee silence is the noncommunication resulting from a conscious decision of employees to hold back seemingly important information, including suggestions, concerns, or questions (Tangirala & Ramanujam, 2008). Detert and Edmondson (2007) reported pervasive barriers to the expression of improvement ideas by organizational employees. Up and down the hierarchy, people were afraid to speak up with apparently helpful, pro-organizational content. The authors noted that employees are failing to provide ideas or input not because they are "checked out" and just do not care but because of fear. The authors lamented that not only organizations fail to capitalize on much untapped knowledge, but employees too feel genuinely hurt and frustrated about their silence and go through increased stress and experience psychological and physiological problems (Tangirala & Ramanujam, 2008).

Just Safety Culture

An environment supportive of open dialogue to facilitate safer practices is often referred to as a *just culture* or a *just safety culture* (Scott-Cawiezell et al., 2006). Scholars also term *just culture* by another name, *psychological safety*. Psychological safety means a supportive work unit in which members believe that they can question existing practices, express concerns or dissent, and admit mistakes without suffering ridicule or punishment (Tucker, Nembhard, & Edmondson, 2007).

The early formulations of a just safety culture were a clear improvement over the notion of blame culture, but they, while giving some leeway to individuals, were still premised on accountability and bureaucratic controls (see Beyea, 2004; Frankel, Leonard, & Denham, 2006). Instead of bureaucratic controls, we believe that a just safety culture should include recent developments in the literature on organizational learning. An organization with a greater ability to learn from incidents is likely to have fewer incidents having an adverse affect on patients than an organization with lesser ability to learn. For every adverse event that affects the patient, there may be hundreds of potential incidents and lower severity incidents that have little or no effect on patients. More effective organizational learning from these potential and lower severity incidents could lead to system improvements that will reduce the risk of adverse events (Cooke, Dunscombe, & Lee, 2007). In other words, from an organizational learning perspective, a just safety culture can be defined as an organization's ability to identify, report, and investigate incidents and to take corrective actions that improve the patient care system and reduce the risk of reoccurrence. Cooke et al. (2007), in their study of a cancer center, found that problems inherent in management practices and organizational systems rather than willingness of the staff to report were major barriers to instituting an effective incident learning system. Further, the lack of follow-up on reported incidents and allocation of insufficient resources to incident investigations hampered organizational learning.

Kirk, Parker, Claridge, Esmail, and Marshall (2007) described the basic features of a just safety culture to include organization's overall commitment to quality, uninhibited reporting and identification of adverse events, quick and thorough investigation of patient safety incidents, extensive formal and informal communication and information sharing of safety issues, organizational learning after a patient safety incident, staff training and education in patient safety, and team working around safety issues.

Organizational Antecedents of Blame and Just Cultures

In the following section, we develop arguments based on two chief premises. The first premise is that sustained improvement in quality and safety has more to do with culture than with improvement techniques and isolated training programs and interventions. As Cohen, Eustis, and Gribbins (2003, p. 334) rightly noted, "Profound cultural change is the first prerequisite for achieving major improvements in patient safety." The second premise is that organizational culture cannot evolve piecemeal but needs an overall organizational approach backed by an HR department that has the necessary capabilities to implement a set of consistent HR practices appropriate for propagating the new and desired form of culture. Our discussions revolve around two alternative management philosophies of control-based and commitment-based management. We argue that the blame culture is more rampant in the control-based management and that the just culture is more widespread in the commitment-based

management. This discussion is then followed by the elaboration of our assertion that organizations need to build organizational capacity in the form of HR capabilities to transition successfully from a blame culture to a just culture.

Two Alternative Management Philosophies

Although each health care organization is likely to have its own unique management philosophy, broadly, health care organizations can be thought of falling along a continuum, one end of which signifies control and the other end signifies commitment (Eaton, 2000; Khatri, Baveja, et al., 2006; Khatri et al., 2007; McGregor, 1985; Truss, Gratton, Hope-Hailey, McGovern, & Stiles, 1997; Vestal, Fralicx, & Spreier, 1997). Each management philosophy, control based or commitment based, results in a different but a consistent set of management practices. For example, narrowly defined jobs, use of time clocks and overtime, specification of rigid quality indicators, and prescription of required training programs are common practices used in a control-based management. On the other hand, broader jobs, flat organizational structure, greater employee participation, and teamwork and cooperation are common in a commitment-based management. Each management philosophy and resultant practices then generate a coherent pattern of employee behaviors that may either undermine or encourage patient safety.

The control-based model assumes that people are incapable of self-regulating their behaviors, and they need constant guidance, reward, and discipline from management. Consistent with this assumption, the natural emphasis of the control-based management is on monitoring employee behavior closely via a variety of control mechanisms. The basic assumptions of the control-based model get manifested in HR management practices and organizational structures. For example, in a control-based organization, hierarchy is tall and communication is quite anemic, mostly top–down. The focus of employee behaviors is on compliance with procedures, instructions, and orders from the top.

The commitment-based management, on the other hand, has two underlying assumptions: (a) People are capable of self-discipline, and given the opportunity and developmental experiences, they would like to seek responsibility and exercise initiative, and (b) people work best when they are fully committed to the organization, and they commit to the organization when they are trusted and allowed to work autonomously. The commitment-based approach relies on creating an environment that encourages the exercise of initiative, ingenuity, and self-direction on the part of employees in achieving organizational goals.

The management practices and systems of the commitment-based organization reflect its basic assumptions about human motivation. Structure of such an organization is relatively flat, and communication and information sharing are extensive and take place in all directions. There is greater prevalence of teams, cooperation, and employee involvement. Employees enjoy greater autonomy and responsibility, and the goals of the management and employees show greater alignment as employees and management work together.

Control-Based Management: Blame Culture

The basic assumptions and underlying management practices in the control-based approach are not inconsequential; they impact employee behavior. For example, employees in the control-based environment follow instructions or orders from above and do just what they are told. They have a sense of indifference toward or disengagement from work. If implemented well, a control-based approach may achieve a satisfactory level of performance, but it cannot achieve the high level needed for a just culture. If not managed effectively, this approach is likely to lead to low employee morale and a climate of mistrust. Employees do not like to take responsibility and feel a sense of frustration and helplessness. Employee turnover and absenteeism are generally high, with a low utilization of human capacity.

The ubiquity of control-based management in health care organizations seems to be a major source of the culture of blame existing in them (Khatri, Baveja, et al., 2006; Khatri et al., 2007; Scott et al., 2005; Scott-Cawiezell, Jones, Moore, & Vojir, 2004; Scott-Cawiezell et al., 2006). The control-based management does not allow much learning to take place in the health care delivery process and sets in motion a "vicious cycle" in which greater incidence of medical errors leads to greater control and regulation of employee behaviors, further strengthening the blame culture and finger pointing.

The control-based management style leads to low motivation and generates negative emotional energy. According to Khatri, Baveja, et al. (2006) and O'Reilly and Pfeffer (2000), the control-based model is designed to prevent undesirable actions and behaviors from a small fraction of employees, about 5% or so. In so doing, it unintentionally imposes constraints on the initiative, creativity, and morale of the other 95% of employees.

Counterproductive hierarchical communication patterns resulting from status differences in control-based management are reported to be responsible for many medical errors (Nembhard & Edmondson, 2006). Physicians have been shown to have ignored important information communicated by nurses, and nurses also

withheld relevant information for diagnosis and treatment from physicians. If a leader takes an authoritative, unsupportive, or defensive stance, team members are more likely to feel that speaking up in the team is unsafe (Nembhard & Edmondson, 2006).

The management systems premised on control are inadequate to meet the challenge posed by the nature of health care delivery process. Although the dynamic nature of health care delivery process requires flexibility, teamwork, and cooperation from employees, the bureaucracy inherent in the control-based management results in system inflexibility and undermines teamwork and collaboration (Newton, Davidson, Halcomb, & Denniss, 2007). A large number of potential hazards within the diagnostic process in health care (test ordering, sample collection, sample delivery, and results dissemination) exist that contribute to delays in the process. Most of these potential hazards occur across the boundaries of different units or departments (Edworthy et al., 2006). The environment in which the health care delivery takes place is usually dynamic, involving numerous patients and providers, significant task time pressures, and multiple sources of information (Schultz, Carayon, Hundt, & Springman, 2007). The collaborative nature of the process stems from the involvement of a wide array of practitioners, who each gather and contribute information about patients. However, many of these providers, hampered by the control-based management practices, experience difficulties in obtaining the information necessary to safely and efficiently proceed with health care intervention. Information is often delayed or missing and, therefore, not available when needed. This often results in providers having to spend considerable time tracking down certain patient information. Even in cases where information appears available, providers find late and inadequate or incomplete communication to be significant performance barriers. There has been considerable exploration of the power of connecting disparate units involved in the clinical work process with an electronic information system as a solution to the problem of communication. Although electronic information systems provide a technical solution to the problem, it is increasingly clear that there needs to be an increased sense of collaboration and unity among professionals, departments, and organizations involved in assuring quality and safety in a work process (Brown, Stone, & Patrick, 2005).

The quality and safety of patient care in a control-based management approach are typically sought by creating a separate quality assurance department. In fact, most quality assurance departments may have been created to suggest to regulators and the larger public that the organization is taking the necessary steps to reduce medical errors (Khatri, Baveja, et al., 2006). Unfortunately, in most health care organizations, these departments are not fully supported and are not the ones that bring to light the major failures in health care delivery (Walshe & Shortell, 2004). Several safety scholars (Garbutt et al., 2008; Khatri, Baveja, et al., 2006; Plews-Ogan et al., 2004; Walshe & Shortell, 2004) pointed out that these departments fail to enlist physicians or clinicians and frequently managers. For example, Garbutt et al. (2008), in their survey of physicians, debunked the conventional wisdom that physicians are "reluctant partners" in reporting errors. The authors found that the problem was not related to physicians' unwillingness to report an adverse event but to inadequacies and lack of follow-up in current reporting systems. Moreover, the traditional quality assurance model monitors specific aspects of care retrospectively and addresses problems on an individual basis rather than on a system level and minimizes input from staff directly involved in delivering patient care (Scott-Cawiezell et al., 2006). One can make a persuasive argument that the traditional quality assurance model is inherently flawed in that it assumes that the key issues of patient safety and quality of care can be managed by a separate department. Given the centrality of quality and safety of patient care to the health care delivery process, we think that the quality and safety have to be built into the entire system.

Commitment-Based Management: Just Culture

The basic assumptions of the commitment-based approach and resultant HR practices impact employee behaviors. Employees show greater initiative, are more innovative, and go beyond their defined job responsibility. They are actively engaged and committed to their work and to the organization. Morale is high, and employees feel a sense of empowerment. Employees take pride in the organization's mission, and their turnover is low.

The commitment-based management is essential in creating a just culture (Khatri, Baveja, et al., 2006; Khatri et al., 2007). It is conducive to a culture of safety via two beneficial effects: the *learning effect* and the *motivation effect*. In the learning effect, the commitment-based management increases learning from mistakes by inducing a "virtuous cycle" in which organizational members report all the medical errors and search extensively for their causes in an open and trusting environment, which is not dependent upon and operates without interference from management. Motivational effect generates high motivation in the workforce and harnesses immense energy emanating from the positive emotions it fosters. Thus, it enhances quality of care and patient safety by improving the morale of the workforce. In the commitment-based management, self-directed and highly energized employees exercise their best effort to provide high-quality patient care.

Honest, open, and ethical dealings and real-time information sharing across levels in a commitment-based organization (Vogus & Welbourne, 2003) build trust in the organization and strengthen system transparency, defined as a willingness of providers and patients to openly and comfortably express their concerns about the delivery of care in a manner that identifies flaws and leads to their elimination, mitigation, or appropriate management (Frankel et al., 2003). Trust and transparency are necessary for triggering an important mechanism of "mindfulness," a heightened organizational awareness toward safety issues (Weick & Sutcliffe, 2003). Mindfulness has been suggested as a critical process in high-reliability organizations that overcome hubris and casualness about safety issues.

Scott-Cawiezell et al. (2006), based on their study of 32 Colorado nursing homes, suggested that trust is a critical element of creating a just culture and reported that the interplay of three critical organizational attributes of communication, teamwork, and leadership results in a just culture through open, accurate, and timely information that flows up and down in the organization, sense of connectedness among staff members, and supportive leadership that articulates expectations. The authors noted, however, that most nursing homes still function under the traditional quality assurance model, which relies on the premises underlying the control-based management.

The quality and safety issues in commitment-based management permeate the entire organization and are not relegated to a separate department or carried out in isolated clinical or other work settings. For example, Plews-Ogan et al. (2004) reported a 20-fold increase in reporting of adverse events and near misses over a period of 12 months after a traditional quality reporting system was replaced with an organization-wide, clinician-based voluntary reporting system.

Usually, leadership is aware of less than 5% of the errors in their system, and the staff members know all of them (Scott-Cawiezell et al., 2006). Managers need to hear from the people in the organization who are closest to work, closest to the patients—that is, from those who are in the best position to recognize problems and have new ideas. Two beliefs are essential preconditions for the free expression of upward voice: First, the belief that one is not putting oneself at significant risk of personal harm (e.g., embarrassment, criticism, or loss of material resources) and, second, the belief that one is not wasting one's time in speaking up (Detert & Edmondson, 2007). In short, voice must be seen as both safe and worthwhile. Such a voice is suppressed in a control-based organization but encouraged in a commitment-based organization.

Solberg, Hroscikoski, Sperl-Hillen, Harper, and Crabtree (2006) investigated an exemplary family physician medical group in Minneapolis-St. Paul to determine the organizational and cultural attributes related to achieving high quality of care. The authors found that the medical group made little use of standing orders. Instead, it relied on extensive involvement of all staff to bring together information that would prompt the clinical action. The work environment was very egalitarian. Teamwork was an early goal in the group's history and fostered using many mechanisms—equal pay for the physicians, a common office area at each site for all clinicians, careful selection of new clinicians who fit the team model, mentoring and extended orientation, and extensive involvement and communication. The management practices and culture were strengthened by hiring a new administrative leader with such interests. Many features of the medical group suggest that the group employed management practices consistent with a commitment-based management philosophy.

Role of HR in Organizational Change and Learning

The dependence of organizational improvement on culture change is due to the fact that, when the values, orientations, and goals stay constant—even when procedures and strategies are altered—the organization returns quickly to status quo (Cameron & Quinn, 1999). Without an alteration of the fundamental values, norms, and expectations of the organization, change remains superficial and short-lived in duration. Furthermore, failed attempts to change, unfortunately, frequently produce cynicism, frustration, loss of trust, and deterioration in morale among organizational members.

Evidence linking the blame culture to poor quality and safety of patient care has accumulated over the years, and interventions to modify the culture are required before attempting to change clinical systems and processes (Scott-Cawiezell et al., 2004; Vestal et al., 1997). Changing the culture so that people believe that speaking up is expected and desired requires fairly far-reaching indications of commitment to change and making fundamental changes to how people get evaluated and rewarded (Detert & Edmondson, 2007). The improvement in communication, teamwork, and leadership is necessary for there to be organizational capacity to create and sustain a just culture (Scott-Cawiezell et al., 2006).

Organizational capacity can be defined as its ability to modify existing practices, care processes, and organizational attributes (Scott et al., 2005). This capacity to create and sustain improvement is antecedent to an organization becoming mindful of the safety practices within their organizations. Health care organizations are increasingly seeking to improve their capacity to learn by better utilizing the knowledge and ideas of people

(Detert & Edmondson, 2007). Unfortunately, they are struggling in their efforts to do so and are not quite sure how to proceed. Most of them have not built any organizational capacity to be able to overhaul their cultures (Khatri, 2006; Scott et al., 2005). Consequently, they are making piecemeal efforts, either trying to find best practices from other health care organizations or relying on outsourcing to achieve the needed transformation (Khatri, 2006; Khatri, Wells, McKune, & Brewer, 2006). However, health care organizations require a substantial adaptation of practice to context, making the best practice approach inadequate, and possibly even counterproductive (Khatri, 2006; Tucker et al., 2007).

Tucker et al. (2007) studied two types of organizational processes in the successful implementation of new practices: *learn-what* and *learn-how*. Learn-what is a bundle of activities that seek to identify best practices and involves identifying existing knowledge. Learn-how refers to a bundle of activities aimed at discovering the underlying science of a better practice so as to operationalize the practice in a target organization. It requires innovation, experimentation, and collaborative problem solving and occurs more frequently in supportive organizational contexts. The authors found that learn-how rather than learn-what plays a central role in implementation success. Learn-how activities are more complex, however, and not all organizations can implement them effectively. Learn-how activities require internal organizational capacity for successful implementation as they cannot be easily copied from others or outsourced (Khatri, 2006; Novak & Stern, 2007; Tucker et al., 2007).

We noted above that the control-based management creates a dynamic in which a blame culture flourishes. Similarly, a commitment-based approach creates an appropriate environment for a just culture. Thus, to be able to move from a culture of blame to a just culture requires that an organization first examines its management practices. If management practices and systems that hinder quality and safety of patient care are diagnosed, the organization will need to implement learn-how processes consistent with a just culture to make the needed changes.

We believe that the HR function has to play a central role in managing organizational culture, change, and learning in health care organizations (Khatri, 2006; Khatri, Wells, et al., 2006; Vestal et al., 1997). To be able to perform such a difficult and complex task as moving an organization from a blame culture to a just culture requires an HR function of the organization to have HR capabilities; the old HR as a bastion of bureaucratic, command-and-control style must be eliminated (Khatri, 2006; Vestal et al., 1997). Ruona and Gibson (2004) argued that HR in the 21st century is emerging as a metaprofession that can accommodate multiple fields, such as organizational behavior, HR, HR development, and organizational development, under one umbrella. According to the authors, the unfolding of four key trends in employment indicates a clear convergence and the birth of a new 21st century HR: (a) increased centrality of people to organizational success; (b) focus on whole systems and integrated solutions (synergies/complementarities in HR practices); (c) strategic alignment of HR and its impact on organizational performance; and (d) the crucial role of HR in managing organizational culture, change, and learning.

Knowledge-intensive, high-contact services, such as health care organizations, have high levels of communication time between customers and service employees, intimacy of communication, and richness of information exchanged during contact (Goldstein, 2003). Greater employee knowledge and skills are needed in such services because unpredictability during the service encounter creates a need for employees who can make continuous and multiple nonprogrammed decisions. Employees need the "ability and authority to achieve results for customers" (Heskett, Sasser, & Schlesinger, 1997, p. 29). Such organizations should focus on development of work systems, training programs, and services for employee well-being as a means to improve employee productivity and satisfaction rather than as a direct means to improve customer satisfaction (Goldstein, 2003).

In view of the ever-evolving organizational forms, HR capabilities should be treated as core organizational capabilities. There are five key dimensions of HR capabilities (Khatri, 2006). First, the chief executive has to have a full comprehension of the key role that HR plays in knowledge-based and service-oriented health care organizations. Simply being supportive and providing resources is not sufficient. In view of the fact that salary and wages constitute somewhere between 60% and 85% of the operating budget in a typical health care organization, the people issues have to be as central as financial and other key operating issues in a chief executive's agenda. The second dimension of HR capabilities pertains to the status of HR in the organization; HR function cannot be relegated to secondary role. HR activities permeate the entire organization, and thus HR department cannot be located far from the action, in a deserted part of the organization. The third dimension of HR capabilities consists of a visionary and professional head of HR function. For example, Khatri, Wells, et al. (2006) reported that health care organizations that hired a visionary and technically competent HR director with experience in other service industries were able to make great strides in changing their cultures. These organizations were also able to comprehend more clearly the link between people management practices and clinical outcomes. Fourth, in view of the

new roles such as organizational change and learning that HR has to undertake, HR employees have to be professionally educated and trained. Perhaps managing people has become far more complex than managing accounts. Thus, if accountants are hired based on their technical education in accounting, HR employees must be hired based on their thorough and deep knowledge and training in behavioral sciences. Not any organizational employee can be assigned to the HR department. The well-educated and trained HR employees can develop highly effective HR tools such as selection instruments, training programs, appropriate compensation strategies, and just and fair performance management systems. On the other hand, it is unfair to expect that clinicians such as nurse administrators can fully grasp the subtlety and ever-increasing complexity of HR function. Finally, the HR function is highly data intensive. Managing it well calls for a computerized strategic HR information system. Such a system in the hands of a visionary HR director and highly trained HR employees would turn management of HR programs and practices into science, making them far more effective.

Implications and Conclusion

The rampant blame culture in health care is a major source of medical errors and poor quality of patient care. We believe that a blame culture is natural in hierarchical, control-based management systems currently ubiquitous in health care organizations. Thus, to move from a blame culture to a just culture, health care organizations first need to move away from an overly compliance-driven, regulated management system to a commitment-based management system that encourages employee participation and involvement in decision making. However, changing a deeply entrenched system is far easier said than done. We propose that health care organizations need to develop organizational capabilities in HR function to do so. The deep-seated cultural problem in health care cannot be wished away or outsourced. Health care organizations have tried quick and temporary fixes in their culture and systems over and over in the past with the help of consultants, but doing so has not worked out for them. They really need to build deep internal HR capabilities that would allow them to develop and implement HR practices to transit successfully from a blame culture to a just culture.

Because our discussion of the control-based and commitment-based management approaches formed the core of this article, we would like to note a few caveats regarding these contrasting management approaches. First, from our discussion in this article, one may surmise as if we are necessarily suggesting that a control-based management model is always bad. This is not true. We believe that, if the control-based model is executed well, it would result in at least satisfactory organizational performance, if not in an extraordinary organizational performance. Moreover, a well-executed control-based management is likely to lead to higher organizational performance than a poorly executed commitment-based management. However, we believe that, if both approaches are implemented equally well, the commitment-based approach will surpass the control-based approach quite significantly. Second, it is hard to find health care organizations that ideally fit either of the two approaches. We have presented our arguments for ideal types for the sake of developing clearer and more coherent arguments. The reality is far more complex, which it always is. Most of health care organizations use mixed practices, although currently they rely preponderantly on control-based strategies. We can think of health care organizations to fall along a continuum of control-based and commitment-based management. The third and last caveat is that commitment-based management does not mean that there is no control used in an organization; rather, control is achieved through creating a commitment in people (Khatri, Baveja, et al., 2006). An organization with control-based approach is likely to appear calm and under control on the surface, but it may be simmering with resentment underneath. On the other hand, an organization using a commitment-based approach may appear chaotic on the surface, but its seeming chaos is a reflection of the unleashed energy in its people.

In our jest for developing persuasive arguments in favor of HR capabilities, we may have overemphasized their importance in managing organizational culture, change, and learning. Presently, there are only a handful of health care organizations that have developed HR capabilities, as discussed in this article. However, based on our interactions with managers in health care organizations and an understanding of health care management literature, we find ever-growing realization that organizational factors including HR play a crucial role in health care delivery process. We are hopeful that in years to come many health care organizations will become a model of excellent HR management.

References

Bagnara, S., & Tartaglia, R. (2007). Editorial: Patient safety—an old and a new issue. *Theoretical Issues in Ergonomics*, 8, 365–369.

Beyea, S. C. (2004). Creating a just safety culture. *AORN Journal*, 79, 412–414.

Brown, G. D., Stone, T. T., & Patrick, T. B. (2005). *Strategic management of information systems in healthcare*. Chicago: Health Administration Press.

Cameron, K. S., & Quinn, R. E. (1999). *Diagnosing and changing organizational culture*. Upper Saddle River, NJ: Prentice Hall.

Catchpole, K. R., Giddings, A. E. B., De Leval, M. R., Peek, G. J., Godden, P. J., Utley, M., et al. (2006). Identification

of systems failures in successful pediatric cardiac surgery. *Ergonomics*, *49*, 567–588.

Cohen, M. M., Eustis, M. A., & Gribbins, R. E. (2003). Changing the culture of patient safety: Leadership's role in health care quality improvement. *Joint Commission Journal on Quality and Safety*, *29*(7), 329–335.

Cook, H. H., Guttmannova, K., & Joyner, J. C. (2004). An error by any other name. *American Journal of Nursing*, *104*, 32–43.

Cooke, D. L., Dunscombe, P. B., & Lee, R. C. (2007). Using a survey of incident reporting and learning practices to improve organizational learning at a cancer care center. *Quality and Safety in Health Care*, *16*, 342–348.

Detert, J. R., & Edmondson, A. C. (2007). Why employees are afraid to speak up. *Harvard Business Review*, May, 23–25.

Eaton, S. C. (2000). Beyond 'unloving care': Linking human resource management and patient care quality in nursing homes. *International Journal of Human Resource Management*, *11*, 591–616.

Edworthy, J., Hignett, S., Hellier, E., & Stubbs, D. (2006). Editorial: Patient safety. *Ergonomics*, *49*, 439–443.

Etchells, E., O'Neill, C., & Bernstein, M. (2003). Patient safety in surgery: Error detection and prevention. *World Journal of Surgery*. doi:10.1007/s00268-003-7097-2.

Farley, D. O., Haviland, A., Champagne, S., Jain, A. K., Battles, J. B., Munier, W. B., et al. (2009). Adverse-event-reporting practices by US hospitals: Results of a national survey. *Quality and Safety in Health Care*, *17*, 416–423.

Flin, R. (2007). Measuring safety culture in healthcare: A case for accurate diagnosis. *Safety Science*, *45*, 653–667.

Fogarty, G. J., & McKeon, C. M. (2006). Patient safety during medication administration: The influence of organizational and individual variables on unsafe work practices and medication errors. *Ergonomics*, *49*, 444–456.

Frankel, A., Gandhi, T. K., & Bates, D. W. (2003). Improving patient safety across a large integrated health care delivery system. *International Journal for Quality in Health Care*, *15*(Suppl. 1), i31–i40.

Frankel, A. S., Leonard, M. W., & Denham, C. R. (2006). Fair and just culture, team behavior, and leadership engagement: The tools to achieve high reliability. *Health Services Research*, *41*(4), 1690–1709.

Garbutt, J., Waterman, A. D., Kapp, J. M., Dunagan, W. C., Levinson, W., Fraser, V., et al. (2008). Lost opportunities: How physicians communicate about medical errors. *Health Affairs*, *27*, 246–255.

Goldstein, S. M. (2003). Employee development: An examination of service strategy in a high-contact service environment. *Production and Operations Management*, *12*(2), 186–203.

Hammer, M. (2007). The process audit. *Harvard Business Review*, April, 111–123.

Heskett, J., Sasser, W. E., & Schlesinger, L. (1997). *The service profit chain*. New York: The Free Press.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: The National Academy Press.

Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. Washington, DC: The National Academy Press.

Khatri, N. (2006). Building HR capability in health care organizations. *Health Care Management Review*, *31*, 45–54.

Khatri, N., Baveja, A., Boren, S., & Mammo, A. (2006). Medical errors and quality of care: From control to commitment. *California Management Review*, *48*, 115–141.

Khatri, N., Halbesleben, J. R. B., Petroski, G., & Meyer, W. (2007). Relationship between management philosophy and clinical outcomes. *Health Care Management Review*, *32*, 128–139.

Khatri, N., Wells, J., McKune, J., & Brewer, M. (2006). Strategic human resource management issues in hospitals: A study of a university and a community hospital. *Hospital Topics*, *84*, 9–20.

Kirk, S. (2005). What we know: Safety culture. *Saferhealthcare*, 1–6.

Kirk, S., Parker, D., Claridge, T., Esmail, A., & Marshall, M. (2007). Patient safety culture in primary care: Developing a theoretical framework for practical use. *Quality and Safety in Health Care*, *16*, 313–320.

Lingard, L., Reznick, R., Espin, S., Regehr, G., & Devito, I. (2002). Team communications in the operating room: Talk patterns, sites of tension, and implications for novices. *Academic Medicine*, *77*, 232–237.

McGregor, D. (1985). *The human side of enterprise. 25th Anniversary printing*. New York: McGraw-Hill.

Meterko, M., Mohr, D. C., & Young, G. J. (2004). Teamwork culture and patient satisfaction in hospitals. *Medical Care*, *42*, 492–498.

Nembhard, I. M., & Edmondson, A. C. (2006). Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior*, *27*, 941–966.

Newton, P. J., Davidson, P. M., Halcomb, E. J., & Denniss, A. R. (2007). Barriers and facilitators to the implementation of the collaborative method: Reflections from a single site. *Quality and Safety in Health Care*, *16*, 409–414.

Novak, S., & Stern, S. (2007). *How does outsourcing affect performance dynamics? Evidence from the automobile industry* (Working Paper 13235), Cambridge, MA: National Bureau of Economic Research.

O'Reilly, C. A. III, & Pfeffer, J. (2000). *Hidden value*. Boston: Harvard Business School Press.

Pace, W. D. (2007). Editorials: Measuring a safety culture: Critical pathway or academic activity? *Journal of General Internal Medicine*, *22*, 155–156.

Plews-Ogan, M. L., Nadkarni, M. M., Forren, S., Leon, D., White, D., Marineau, D., et al. (2004). Patient safety in the ambulatory setting: A clinician-based approach. *Journal of General Internal Medicine*, *19*, 719–725.

Pronovost, P. J., Weast, B., Holzmueller, C. G., Rosenstein, B. J., Kidwell, R. P., Haller, K. B., et al. (2003). Evaluation of the culture of safety: Survey of clinicians and managers in an academic medical center. *Quality and Safety in Health Care*, *12*, 405–410.

Ramanujam, R., & Rousseau, D. M. (2006). The challenges are organizational not just clinical. *Journal of Organizational Behavior*, *27*, 811–827.

Ruona, W. E. A., & Gibson, S. K. (2004). The making of twenty-first-century HR: An analysis of the convergence of HRM, HRD, and OD. *Human Resource Management*, *43*(1), 49–66.

Schultz, K., Carayon, P., Hundt, A. S., & Springman, S. R. (2007). Care transitions in the outpatient surgery preoperative process: Facilitators and obstacles to information flow

and their consequences. *Cognition, Technology and Work*, *9*, 219–231.

Schutz, A. L., Counte, M. A., & Meurer, S. (2007). Development of a patient safety culture measurement tool for ambulatory health care settings: Analysis of content validity. *Health Care Management Science*, *10*, 139–149.

Scott, J., Vojir, C., Jones, K., & Moore, L. (2005). Assessing nursing homes' capacity to create and sustain improvement. *Journal of Nursing Care Quality*, *20*, 36–42.

Scott-Cawiezell, J., Jones, K., Moore, L., & Vojir, C. (2004). Nursing home culture: A critical component of sustained improvement. *Journal of Nursing Care Quality*, *20*, 341–348.

Scott-Cawiezell, J., Vogelsmeier, A., McKenney, C., Rantz, M., Hicks, L., & Zellmer, D. (2006). Moving from a culture of blame to a just culture in the nursing home setting. *Nursing Forum*, *41*, 133–140.

Solberg, L. I., Hroscikoski, M. C., Sperl-Hillen, J. M., Harper, P. G., & Crabtree, B. F. (2006). Transforming medical care: Case study of an exemplary, small medical group. *Annals of Family Medicine*, *4*, 109–116.

Sorra, J., & Nieva, V. (2004). Hospital survey on patient safety culture (AHRQ Publication No. 04-0041). Rockville, Maryland: Agency for Healthcare Research and Quality.

Stryer, D. (2004). *Patient safety, research, and evidence: Getting to improved systems*. *Journal of General Internal Medicine*, *19*(7), 808–809.

Tangirala, S., & Ramanujam, R. (2008). Employee silence on critical work issues: The cross level effects of procedural justice climate. *Personnel Psychology*, *61*(1), 37–68.

Truss, C., Gratton, L., Hope-Hailey, V., McGovern, P., & Stiles, P. (1997). Soft and hard models of human resource management: A reappraisal. *Journal of Management Studies*, *34*, 53–73.

Tucker, A. L., Nembhard, I. M., & Edmondson, A. C. (2007). Implementing new practices: An empirical study of organizational learning in hospital intensive care units. *Management Science*, *53*, 894–907.

Vestal, K. W., Fralicx, R. D., & Spreier, S. W. (1997). Organizational culture: The critical link between strategy and results. *Hospital & Health Services Administration*, *42*, 339–365.

Vogus, T. J., & Welbourne, T. M. (2003). Structuring for high reliability: HR practices and mindful processes in reliability-seeking organizations. *Journal of Organizational Behavior*, *24*, 877–903.

Walshe, K., & Shortell, S. M. (2004). When things go wrong: How health care organizations deal with major failures. *Health Affairs*, *23*, 103–111.

Weick, K. E., & Sutcliffe, K. M. (2003). Hospitals as cultures of entrapment: A re-analysis of the Bristol Royal Infirmary. *California Management Review*, *45*, 73–84.