Accountability: Challenges to Getting It Right

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Abstract: Patient safety experts debated accountability in health care at the 2014 annual National Patient Safety Foundation Congress. The debate reflected the struggles organizations are facing with ensuring a responsible workforce committed to patient safety versus the need to redesign flawed systems that are error prone. The question, “is it the systems or the individual?” was at issue. This article proposes that it is the wrong question, and the failure to apply patient safety science in clinical practice is contributing to the ambiguity fueling the debate. To transform accountability from a source of confusion to a powerful tool for fulfilling health care’s fiduciary responsibility to protect patients from harm, we need to reframe our approach. This article presents the science and strategies to create clarity that will redirect the dialogue from a debate in which accountability resides to one about learning for improvement when adverse events occur.

Key Words: accountability, blame, human error, patient safety

The opening session at the 2014 annual National Patient Safety Foundation Congress asked whether “Certain safety practices should be inviolable, and transgressions should result in penalties, potentially including fines, suspensions and firing.” The debate between 2 patient safety experts rapidly evolved into a dialogue about individual accountability versus a systems focus. The debate is doomed to a death spiral of endless discussion because the question, “is it the systems or the individual?” is the wrong one. The correct question after an unintended adverse event is, “what can we learn about our systems and the decisions clinicians make while navigating them?” Accurately answering these questions will differentiate human error from willful rule breaking, a core element of accountability. Both the debate and the literature clearly advise against punishing human error, but the focus on accountability for violations or actions is a blaming behavior, thus creating confusion. To avoid blame, we need to hold individuals accountable for their decisions, not their actions.

We cannot change something we did not intend, but we can change the decisions that led to that unintended event. A common and flawed approach to error remediation is to identify a missed step in the process that led to the outcome and hold the worker responsible for failing to accurately complete the procedure. The myth of personal control views the missed action as a personal choice.5-7 If only they were more careful and made a different decision, the bad event would never have occurred. The transporter who arrives at the diagnostic department with the wrong patient should have checked the patient identification. The nurse who administered the wrong drug should have read the vial more carefully. This flawed thinking is driven by the belief that the event is a choice under the control of the worker. The transporter did not make a decision to omit the bracelet check; he/she forgot or was interrupted and missed it. The nurse who failed to read the vial may have committed a cognitive error of pattern matching and actually thought that he/she had checked the vial. Determining why the procedure was not followed illuminates the underlying human error and debunks the myth that the individual chose to ignore the rule.

A widely accepted viewpoint espouses enforcing rules as a mechanism for achieving excellence. Rule enforcement does effectively communicate high standards when an individual purposefully disregards a good rule. However, when rule breaking is unintentional, such enforcement is counterproductive. Holding the transporter or the nurse accountable for not following rules they never intended to break constitutes punishing human error. Without understanding the context for the decisions, we lose the opportunity to identify our flawed systems.5-7 If transporters forgetting to check the identification bracelets is a pervasive problem, this should lead to developing systems (e.g., bar scan identification, checklists, or verbal confirmation of patient identity with the receiving department) for intercepting the error. Identifying look-alike vials and assessing how these are stocked and accessed on the nursing units support reducing pattern matching errors. Unintended adverse events should be examined to understand how individuals interact with the systems designed for them so that a thoughtful response can be developed. Organizational beliefs and values around accountability will influence that response.

THE GOALS OF ACCOUNTABILITY

Wikipedia allows individuals to participate in defining words and could thus be seen as a proxy for how accountability is understood in the American culture. In Wikipedia, the definition of accountability highlights the words blameworthiness, liability, and being called to account for one’s actions.8 The patient safety literature echoes this perspective, with calls for organizational accountability that invoke punishment as an essential element and suggest that the lack of sanctions is impeding our progress.2-4 Although there is extensive literature about individual accountability,3,13 there is less information about organizational accountability, and it has been noted that it is poorly understood.14

Accountability at its finest communicates organizational values, establishes boundaries for acceptable behaviors, explicates excellence, and creates psychological safety within a just culture that ultimately safeguards patients. At the core of accountability are organizational beliefs about how human error and rule breaking are managed. If the goal of accountability is to change future behaviors and prevent errors, then accountability must focus on learning and distinguishing between human error and egregious rule breaking. Every unintended adverse event should be examined for accountability and culpability to ascertain when systems redesign and/or sanctions would be appropriate. Every event requires accountability, but a much smaller number involve the need for sanctions. The clinician who forgets to clean his hands and complies with a coworker’s prompting should be managed differently from the clinician who ignores a coworker’s prompt and omits hand hygiene (HH). Both clinicians failed to clean their hands (the action), but their decision determines the consequences. If the organization fails to punish physicians who make a decision to violate the HH rules and enforces the same rules for nursing, the organizational values communicated are that powerbrokers are above the law.

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Practical application of organizational accountability is complex, and there is a lack of literature to support implementation. In the following sections, composite cases are presented to create a mental model for organizational accountability in which individuals are held accountable for their decisions instead of their actions.

FLAWS IN HOLDING INDIVIDUALS ACCOUNTABLE FOR THEIR ACTIONS

The first case involves a program director who issued a written warning to a critical care fellow in response to an incident report documenting her failure to adhere to the central venous line blood-stream checklist, despite a nurse prompting her. A nurse manager met with a well-respected nurse on her unit, to inform her that it had been reported that she failed to perform HH in 7 instances in less than an hour. Her gross negligence would be reflected in her performance evaluation. Aren’t these 2 events inviolable safety practices? Isn’t failure to meet them a punishable transgression? The answer lies in understanding the individuals’ decisions and not their actions.

In case 1, a novice nurse on the night shift deployed the rapid response team (RRT) when she was unable to detect a blood pressure on her patient. The fellow in charge of the RRT made the working diagnosis of decompensated sepsis. Unable to establish vascular access, she inserted a femoral central venous line. As she was about to place the line, the nurse reminded the fellow that they had trays with gowns available. The fellow responded that there was no time and later documented that the line was inserted under emergent conditions without full barrier precautions, necessitating replacement as soon as possible and no later than 24 hours. The novice nurse’s inexperience led her to file an incident report. Did the fellow willfully disregard safety mandates? No, she made a correct judgment in accordance with the policy that provides for exceptions in emergent circumstances. Judging her actions instead of her decision transforms accountability into blame. It is a form of organizational error in which accountability is inappropriately invoked under the guise of holding practitioners to high standards. Instead of communicating high standards, it communicates unfairness.

In the second example, a nurse accompanied an oncology fellow to the bedside of her patient for a paracentesis. She performed HH and the time out prior to beginning the procedure. After donning full protective attire, the fellow realized that the tray did not contain a local anesthetic. The nurse sped out of the room for another tray containing a local anesthetic. As she was removing her gloves, her occupied hands and task urgency distracted her from HH upon room exit. Her hands were full with the medication, syringes, and alcohol swabs, making HH impractical upon reentry. When she arrived at the bedside, she immediately assisted the waiting fellow, forgetting the HH. During the course of the procedure, the nurse left the room for forgotten supplies on 2 more occasions, creating 4 additional missed HH opportunities. At the completion of the procedure, the nurse gathered up the supplies for disposal. Leaving the room with gloved hands created a seventh missed HH event in the space of 35 minutes. Was the nurse’s failure to perform HH a willful violation? No, the decision that led to the error was responding as rapidly as possible to time-pressured requests that distracted her attention away from the HH. Holding her accountable for her actions rather than her decision constitutes punishing human error.

In both cases, judging the clinicians’ actions without ascertaining their intentions created the illusion of willful disregard of the rules. Although the safety literature recommends that we hold individuals accountable for their decisions, there is limited evidence of application in clinical practice. The next cases illustrate that a systems focus that ignores an individual's decision is just as faulty.

FLAWS IN ATTRIBUTING INDIVIDUAL ACCOUNTABILITY TO THE SYSTEM

At the conclusion of an abdominal surgery, the sponge count was incorrect, and a film was ordered in compliance with policy. Meanwhile, the surgeon performed a manual wound sweep and declared that the missing sponge was outside the patient. The surgeon closed the patient, and, as he was about to leave the operating room (OR), the nurse reminded him that the film was still pending. The surgeon did not respond and left. When he was notified that the radiologist had confirmed a retained sponge, he responded that he was in transit to the airport and to contact his covering colleague. Ultimately, the retained sponge was removed by the second surgeon after the patient had spent an additional 75 minutes on the table. At the root cause analysis (RCA) meeting, the surgeon stated that he was unaware that he needed to remain for the results of the film because there was no mention of it in the policy. Although everyone else at the RCA believed that his excuse was disingenuous, no one clarified how his decision was meant to serve the patient. The RCA attributed the event to human error arising from procedural ambiguity. In this instance, the organization accepted the surgeon’s version of events without further investigation. Why he chose to leave the OR when the film was still pending is unexplained by his statement that he did not know the policy. There was no clarification about why he did not answer the nurse who reminded him that it was pending.

The hospital’s administration prided itself on a systems focus and believed that system redesign (in this case, rewriting the procedure) was the most effective approach. The focus on individual behaviors had long since been abandoned under the belief that it was the systems and not the individual. The organizational values drove their response to the surgeon’s actions with the count policy revised to specify that the attending surgeon must remain in the OR vicinity for the results of the radiology report. The organization failed to ascertain the surgeon’s intentions and his volitional decision, losing the opportunity to appropriately invoke sanctions. Did his decision involve human error? No, his decision was a purposeful disregard of a safety practice. Punishment in this situation would have communicated organizational values that we expect staff to adhere to safety mandates and that there will be consequences for purposeful disregard. If this same situation occurred because the surgeon was suddenly called into another OR to help salvage a patient, it would not constitute egregious rule breaking. Punishment would be completely inappropriate because the decision was not purposeful disregard of the rule; the decision was to rescue a patient. It underscores the fallacy of viewing the action of leaving the OR before the x-ray results are available as the foundation for accountability. When organizations wrongly apply a systems approach to avoid punishing organizational powerbrokers, they are betraying the public’s trust and communicating that safety mandates are optional. Organizational accountability that ensures high standards may need to invoke rule enforcement, as the next case illustrates.

A patient was admitted for an elective total hip replacement with a documented anaphylactic reaction to codeine. The order set contained several standard medications including Percocet (oxycodone/acetaminophen). The orthopedic resident was presented with 8 safety alerts, and he rapidly overrode them by checking the box, benefits outweigh the risks. The top alert in red was the warning that the patient had a serious allergy. In the incident investigation, the resident reported that he did not remember seeing the alert. The pharmacist missed the override because
the volume of alerts was overwhelming and unmanageable. The nurse caring for the patient received the alert but had more urgent tasks that needed to be addressed. She intended to return to it later but forgot. The next nurse caring for the patient administered the Percocet (oxycodone/acetaminophen). She retrieved the medication from the automated drug cabinet. The nurse should have then taken the bar code scanner to the bedside but instead omitted that step. The nurse manually performed the dual patient identifier check using the identification bracelet. There was no allergy alert bracelet. After the patient consumed the medication, the nurse returned to the cart and scanned the patient bracelet from a bracelet book. The allergy alert presented, and the nurse realized the error. She immediately paged the resident, who ordered Benadryl (diphenhydramine). When the nurse entered the room to administer it and disclose the error, the patient began describing symptoms of angioedema. The nurse notified the resident, who examined the patient. He ordered steroids, an H2 blocker, and around-the-clock Benadryl (diphenhydramine). The patient was transferred to the intensive care unit, where she spent the next 24 hours under observation. The patient recovered, but it was a frightening event.

Did the nurse make a decision to omit the scanning of medications? To answer this question requires an understanding of the context and intentions. The scanner was on the medication cart, and the carts technically fit into the room. However, to scan the patient bracelet frequently required moving chairs, walkers, over-bed tables, and the intravenous pole. Visitors needed to step outside the room and the chair relocated. The workload burden was daunting and had led to the creation of a work-around. For unscheduled medications, the nurses had created a bracelet book that would allow them to scan the bracelet on the medication cart after the drug had been administered. They felt that, with extra vigilance, the risks could be effectively managed for the gains in time savings. The absence of errors, the enhanced time savings, and the lack of leadership intervention all supported the normalization of deviance. The goal of the work-around was to facilitate more rapid administration of analgesics for patients in pain. The nurse's decision was to follow the normal practice of using the bracelet book, and the action was to omit the use of the scanner.

To reduce punishment of errors, the organization had recently committed to implementing a just culture. An algorithm was used at every RCA to distinguish when it was the systems or the individual. If it was a systems issue, then no employees were to be punished. At the RCA, the algorithm attributed the clinician's actions to flawed systems. The RCA team recommended system redesign and ignored the issues of noncompliance. The system fixes included purchase of technology (handheld scanners) and redesign of the electronic alerting system. The system fixes would take months to implement, and in the meantime, patients continued to be at risk. Relying on the work of Pellegrino,16 Sidney Dekker eloquently describes the dilemma that this RCA team faced. . . . Systems are not enough. Of course we should look at the system in which people work, and improve it to the best of our ability. But safety critical work is ultimately channeled through relationships between human beings (such as in medicine), or through direct contact of some people with risky technology. At this sharp end, there is almost always a discretionary space into which no system improvement can completely reach. Rather than individuals versus the systems, we should begin to understand the relationship and roles of individuals in systems' (pp. 131–132).

Senior leaders clarified that the just algorithm was a tool for determining the need for punishment. It was not intended to create a blameless approach that discounted rule breaking. The RCA team was charged with immediately implementing measures to manage the proximal factors. A myriad of system changes were proposed that touched pharmacy, prescribers, and nurses. Recognizing that the workload burden was driving the noncompliance with bar scanning, patient care technicians were to be deployed to a patient's room to clear a path for the medication carts for unscheduled medications. If the workload burden remained unmanageable, other options would be explored. Assessing the staffing needs to support safe care delivery constitutes a core organizational accountability that is frequently omitted when practice change occurs. Nurses were informed that the use of bracelet books was banned and compliance with scanning was mandatory. Failure to follow procedures in the absence of an error would carry consequences. The organization redesigned the systems and enforced the rules to guide future decisions.

Many organizations struggle with how to differentiate a decision from an action. After all, wasn't the fellow's disregard of the barrier precautions a decision that constitutes rule breaking? Didn't the nurse who omitted the use of the scanner decide that the rules of medication safety were irrelevant?

### TABLE 1. Differentiating Actions From Decisions

<table>
<thead>
<tr>
<th>Case</th>
<th>Action (What)</th>
<th>Decision (Why)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The fellow omits central line full barrier precautions</td>
<td>The fellow rescues the patient from hemodynamic collapse</td>
</tr>
<tr>
<td>2</td>
<td>The nurse omits HH 7 times in 35 min</td>
<td>The nurse responds to time-pressured requests for a procedure in process</td>
</tr>
<tr>
<td>3</td>
<td>The surgeon leaves the OR while x-ray is pending for wrong count</td>
<td>The surgeon leaves the patient to meet a personal commitment</td>
</tr>
<tr>
<td>4</td>
<td>The nurse bypasses the medication scanner for drug administration</td>
<td>The nurse follows unit norms to more rapidly respond to patients in pain</td>
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### DISTINGUISHING DECISIONS FROM ACTIONS

The clinician's action is “what” happened and the decision is “why” it happened (Table 1).

In the literature, the underlying context (the why) has been described as the second story. The first story is a description of the event (what happened) with explanations attributed to obvious factors with simplistic fixes.17 In the central line and HH events, the first story is that the staff failed to follow the protocol. Answering the question, “is it the systems or the individual?” with individual accountability for the adverse event isolates the individual from the system. The simple solution is to reflect back to them about their performance deficit and invoke consequences for rule breaking without instituting effective change (Table 2).

In the case of the retained sponge, the first story is the lack of a rule in the policy. This time, the organizational answer to “is it the systems or the individual?” was that it was the system and the individual's decision is ignored. Rewriting the policy allows the organization to avoid confronting noncompliance.

The second story seeks to understand the individual's behavior as well as the larger world as it unfolded during the event. Seeking second stories is motivated by a belief that the individual is an
TABLE 2. Responses to First and Second Stories

<table>
<thead>
<tr>
<th>Action First Story:</th>
<th>Actual Response to Action</th>
<th>Decision Second Story:</th>
<th>Why It Happened</th>
<th>Appropriate Response to Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed to follow central line protocol</td>
<td>Written warning in file</td>
<td>Rescued the patient from hemodynamic collapse</td>
<td>Identify systems leading to the “failure to rescue” event</td>
<td></td>
</tr>
<tr>
<td>Disregard of HH protocol</td>
<td>Performance evaluation to reflect substandard performance</td>
<td>Rapidly responded to urgent requests to meet patient care needs</td>
<td>Redesign system to reduce interruptions that would require HH in a time-pressured manner</td>
<td></td>
</tr>
<tr>
<td>Retained Foreign Body</td>
<td>Rewrite the policy</td>
<td>Disregard of policy to meet personal commitment</td>
<td>Sanction the surgeon for intentional rule breaking</td>
<td></td>
</tr>
<tr>
<td>The nurse bypassed the medication scanner</td>
<td>Education about the importance of using the medication scanner</td>
<td>The nurse followed unit norms to more rapidly respond to the patient's pain requests</td>
<td>Reduce the workload burden to facilitate compliance with safety mandates</td>
<td></td>
</tr>
</tbody>
</table>

integral part of the system and that the two are inseparable. Recognition of the integration of the individual within the system illuminates a path for improving systems as well as holding individuals accountable for their decisions. The starting point of the second story is a search for the reason why the clinicians thought they were doing the right thing instead of trying to prove why they went wrong.\(^6\) In the central line case, the fellow’s decision was to rapidly establish vascular access for a morbidly ill patient. Omitting the full barrier precautions is the action, a necessary consequence of the decision. When we rely on the first story, lack of compliance with full barrier precautions is mistakenly identified as the decision. In the case of the omitted HH, the decision was to rapidly respond to time-pressured requests that prevented the nurse from accessing the hand gel at the doorway. The first story attributes the lack of HH to disregarding the rule rather than an oversight from the production pressures associated with a poorly organized bedside procedure.

In the case of the missed sponge, the first story is that the surgeon left the OR because of an incomplete policy. When we pursue the second story and seek to understand why he never responded to the nurse informing him that the film was pending, we communicate that his action at the time is relevant and needs an explanation. When he is asked to clarify why he was unavailable to remove the sponge, we are exploring his decision and sense of accountability to his patients. Soliciting other surgeons’ perceptions of the need to remain in the vicinity of the OR for pending films informs the organization about the scope of the problem. Is this an isolated case or a systemic issue? The second story provides the context for the surgeon’s noncompliance with safety mandates. At the time of the surgeon’s premature departure, the staff members did not call out to have anyone assist them in rescuing the patient from an additional 75 minutes on the OR table. Pursuing why the staff could not rescue this patient in a timely manner is crucial for creating systems to prevent patient harm.

The first story for the medication misadministration is the nurse’s omission of the use of the medication scanner. The second story informs us about the workload burden preventing timely response to patients in pain. If the workload burden is not addressed, then the system will always be at risk for a work-around. Organizational accountability requires that the necessary resources are provided to support safe patient care. Enforcing the rules without correcting the system deficiencies constitutes a lack of organizational accountability.

Table 2 contrasts the organizational response to the first and second stories. In the 2 cases in which the individuals were held accountable for their actions (the fellow for the central line bundle, the nurse for HH), sanctions are inappropriately invoked and the latent safety threats are ignored. In the case in which the system was identified as the source of the event instead of the decision (the surgeon prematurely departs the OR), the organization fails to appropriately apply sanctions. Believing that if the system is flawed then the individual is not accountable eliminates the need to confront noncompliant workers, as seen in the case of the medication misadministration. It underscores why asking “is it the systems or the individual?” is an impediment to creating meaningful change.

SEPARATING THE INDIVIDUAL FROM THE SYSTEM

The first 3 cases failed to examine the systems driving the decisions. Unless the systems are redesigned, the safety threats live on.\(^5\),\(^7\),\(^17\),\(^18\) In the case involving the critical care fellow, determining why early warning signs of deterioration were ignored, late deployment of the RRT, and supervision of novice nurses on the night shift should all be investigated to better protect patients. If the patient had been rescued before hemodynamic collapse, the critical care fellow may have had the opportunity to use full barrier precautions. In the situation with the missed HH opportunities, system redesign should consider a checklist for bedside procedures or redesign of the paracentesis tray. If the necessary supplies are taken into the room, it eliminates the need for repeated HH. The failure of staff to summon assistance when the surgeon violated well-known safety mandates was not examined. There was no “stop the line process” for noncompliant surgeons. An infrastructure of support for staff members who witness unsafe behaviors needs to be implemented. In the case of the medication misadministration, the RCA team initially identified the systems as the cause so that the individual’s actions were ignored and the safety threats persisted.

The opportunities to advance safety are lost when we decide to separate the individual from the system. Focusing on the critical care fellow’s action without examining the systems leaves patients at risk for death from undetected sepsis. Counseling the registered nurse about her failed action to perform HH without redesigning the systems ensures that the event will recur. The surgeon’s rule breaking requires sanctions as a mechanism for future prevention. Otherwise, he has no incentive to follow the rules. If a stop the line process had been in place in which a surgeon-in-chief was called to manage a conflict in the OR, the outcome might have been different. If the surgeon knew that he was accountable in real time to a respected authority figure and that noncompliance involves consequences, he may have made arrangements for a colleague to be available in the OR when he left for the airport. In the case of the
medication misadministration, providing the resources to manage the workload burden is the foundation for compliance and is essential for achieving sustainable safety gains. Advancing patient safety means it is both the systems and the individual.

**ACCOUNTABILITY IN THE LITERATURE**

Examples in the literature advocating accountability describe the first story with the actions deemed worthy of sanctions. The authors do not share information about the volitional decisions and the context to accurately determine willful disregard for safe patient care, creating the impression that it is the actions that are blameworthy instead of the decisions. The authors acknowledge that care must be taken to ensure that we are not punishing individuals for dysfunctional systems, but they are silent about the accompanying systems. The experts explicate the concepts that support a just culture in which human error is not punished. Conflict is created between their stated goals and actual implementation in the case scenarios because they fail to distinguish the volitional decision from unintended actions. The absence of a second story deprives the reader from understanding the context and distinguishing between the action and the decision. There is consensus that this is a complex and difficult issue that will likely require an ongoing dialogue to support effective solutions.

**STRATEGIES FOR GETTING IT RIGHT**

**Clarify the Values**

The starting point for accountability is with understanding the organizational beliefs about errors and rule breaking. If rules enforcement is a cornerstone of accountability and the underlying reasons the rules are not followed are deemed irrelevant, then the first story will suffice and a just culture will be sacrificed. If the goal is to build a safer organization on a foundation of fairness and robust systems, then organizations will need to distinguish human error from intentional violations to ensure that sanctions are appropriately imposed.

**Seek the Second Story**

In the wake of an unintended adverse event, staff members are frequently bewildered about why an action they have routinely performed has suddenly turned out so wrong. They need a non-judgmental individual to help make sense of it all. This is accomplished by reconstructing the unfolding events. Skilled individuals performing incident investigation should focus on why individual actions are frequently bewildered about why an action they have routinely performed has suddenly turned out so wrong. They need a non-judgmental individual to help make sense of it all. This is accomplished by reconstructing the unfolding events. Skilled individuals performing incident investigation should focus on why individual actions are deemed relevant, then the first story will suffice and a just culture will be sacrificed. If the goal is to build a safer organization on a foundation of fairness and robust systems, then organizations will need to distinguish human error from intentional violations to ensure that sanctions are appropriately imposed.

**Identify the Decision**

The action is what went wrong and the decision is why it happened. Although this may sound like a clear and easy concept, it is remarkably difficult to translate into practice. Why is not the failure to use the bar scanning device the decision? Because it tells us what the individual did wrong and the story ends with simple rule enforcement. The latent safety threats remain hidden, and the hard work of creating safety in resource-constrained environments is avoided. The first story leads to simplistic solutions that do not contribute to a safer environment. The same error will lay in wait for a time-pressed clinician to fall into, and whether a patient sustains serious harm is all a matter of luck. Understanding the decision identifies the dysfunctional systems in need of repair. Organizational accountability involves creating systems to support frontline staff, as opposed to mandating rules to comply with poorly designed systems.

**Stop Holding Individuals Accountable for Their Actions**

Hold them accountable for their decisions. This is crucial to creating a just culture. It means that the surgeon who leaves the OR to rescue another patient and does not wait for the radiology results for a retained foreign body is not punished. It means that when a surgeon does not adhere to the practice of waiting for a film to identify the retained sponge that we do not rewrite a policy to accommodate his excuse. Context and intentionality matter and differentiate human error from egregious rule breaking. When decisions represent egregious rule breaking, then sanctions communicate acceptable boundaries and establish standards of excellence.

**ANSWERING THE QUESTION**

How does the perspective presented here inform the answer to the opening question? Should certain safety practices be inviolable and transgressions result in penalties, potentially including fines, suspensions, and firing? The answer is no if the transgression is a result of human error. If the transgression involves egregious rule breaking, it does not matter if the practice is inviolable; it is inexcusable and sanctions need to be invoked. The dialogue about “is it the systems or the individual?” is unnecessary; it is both.

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