Paul Hofmann has given us a comprehensive blueprint for organizing our thinking about how we address management errors and the organizational considerations therein. In offering this excellent analysis, he provides us with many different bases for understanding why managers are reluctant to acknowledge their mistakes. He also provides an array of reasons for considering the wisdom of recognizing errors, acknowledging them openly, and making them the subject of discussion and analysis in order to advance management effectiveness and establish an iconic commitment to integrity. There can be no argument that acknowledging errors bears some risk for the manager. Certainly, however, the risks to management, quality, corporate culture, and public trust that may result from ignoring or covering up mistakes are far greater. After all,
the health system executive has no higher responsibility than protecting the
eexistence and availability of the healthcare assets that belong to the community,
which is not possible without the trust of that community. The greatest risk
management faces is the loss of that trust.

This commentary elaborates on some areas in which further exploration
may be interesting.

1. Because much of the paradigm for addressing errors constructively is
   based on the behavior of clinicians, do significant differences exist
   between the worlds of clinical and management decision making that
   preempt use of the clinical model for informing management process?

2. Can the typology of what constitutes a mistake be structured in other
   ways that may lend additional perspective and be instructive?

3. Many of the issues presented are management decision errors made
   between “good and bad” choices, or “right and wrong” choices. Is
   there more to be learned from looking further into the gray area by
   assessing the mistaken decisions made between “good and good”
   choices, or “bad and bad”?

Are Clinical and Management Decision Making Preclusively Different?

Healthcare management and clinical leadership have long been segregated
organizational endeavors, wary of one another and observing different sets of
rules, and often they have been reluctant partners in the dance of organizing
and providing patient care. The focus of the two groups is frequently different. Are these differences significant enough that management cannot use the clinical paradigm as a model for learning to better address management mistakes?

Typically, the difference is characterized as “patient care needs” versus “organizational needs.” Sometimes this is a euphemism for the perception that clinicians want what is good for the patient while managers want what is profitable. This may be a possible area of conflicting focus. Is this an issue that inalienably separates clinicians’ and managers’ decision making and precludes using the clinical model for improving how we cope with management errors?

• There is not necessarily a conflict between a management decision for the good of an organization and a clinical decision for the good of a patient (e.g., a decision to cease performing cardiovascular surgery in a low-volume program).

• Nor is there necessarily a conflict between an organization’s profitability and good care for patients (e.g., an institutional commitment to build a neurosurgical center of excellence in order to attract more elective, paying patients).

• Ample evidence (Bonner 1957) indicates that clinicians have long made individual decisions on the basis of profitability (e.g., physicians choosing to leave inner-city communities for the greener fields of the suburbs).

• Regardless, in either the management or clinical environment a decision that is a mistake could be subjected to the same rigorous analysis and
would benefit from efforts to reduce the likelihood of subsequent error.

Nothing in the variance between clinical and management focus precludes the relevance of the clinician experience with reviewing mistakes from informing the improvement of management decision making.

Another difference between health system management and clinician decision making can be defined on the basis of a clinician’s proper focus on the benefit to an individual patient or effectiveness of an individual service (individual focus) versus management’s appropriate focus on the benefit to serving the entire community (population focus) or to the success of the organization as a whole. Is this a gulf so big that managers on the one side cannot learn to better address management errors from clinicians on the other side?

- The immediate impact and the resulting rights of an individual patient affected by a clinical error are probably clearer than are the burdens on and rights of an entire community affected by a bad healthcare management decision.
- The quality-of-care responsibilities of a clinician to a patient are more clearly established and more widely accepted than the responsibilities of a health system manager to the community being served (or even to the organization as a whole).
- The clinicians’ mandate to “do no harm” is a powerful standard that has no comparable edict in the managers’ protocols.
Similarly, management’s outlook that errors are an acceptable part of responding with appropriate vigor to a changing environment does not translate well in clinicians’ expectations.

The gulf between clinicians and managers in defining errors and evaluating the appropriate response to errors may be large. This does not, however, preclude being able to transfer the clinical model for learning from errors to improve outcomes nor does it preclude the effectiveness of using such a process to establish a positive organizational learning culture.

Analyses of the Sources and Causes of Management Errors

The Hofmann article offers various detailed analyses of the sources and causes of management errors from a variety of perspectives. These analyses and typologies provide much insight into how to address a management error, what the risks are, and what remedies may be necessary and effective.

A different perspective might offer different insight. As an alternative, one might rely on an analysis of management errors as being rooted in only three critical factors. In this more straightforward typology, all management errors can be attributed to (1) performance failure, (2) failure of judgment, or (3) ethical failure. Each may be viewed as individual, structural, or cultural factors.

Performance failures are those that may result from inadequate skills, poor motivation, poor oversight and supervision, an inadequate or defective decision-making process, neglect in seeking appropriate expertise and input or
failure to use available information, poor organizational preparation, ignorance of the organization’s own decision-making processes, or failure to observe regulatory requirements. Actions in response to management mistakes resulting from performance failure must address organizational processes. If the source of the error was an individual failure, management supervision and development processes must be reviewed and strengthened. Even when the error is clearly singular and the result of individually unwarranted action and when the error can be attributed solely to the failure of one individual, disciplinary actions directed at the individual are only the beginning of a remedy. Preventing future mistakes depends on improving the organization’s processes. Appropriate remedy relies on ensuring the adequacy of communication processes, the thoroughness of planning and decision-making participatory processes, the soundness of management skills training and supervision, the presence of an organizational culture that does not accept laziness or expedience, and the availability of adequate resources for management to fulfill its responsibilities.

If the performance failures can be viewed as seated in management processes, judgment failures are those that result primarily from inadequate leadership processes. Mistakes resulting from judgment failure are rooted in the unsatisfactory establishment of an ethical and supportive management culture that encourages open discussion, challenge, and risk taking. Such a culture must encourage quality in management, exploration of options, and open deliberation. Such qualities need not immobilize the decision-making process, but the culture
must place value on the careful and deliberate exercise of management judgment. Weighing risks and rewards openly is the hallmark of a culture that encourages good judgment and does not punish mistakes that are engendered within the participatory management process. Actions taken in response to management mistakes that are judgment failures should first assess the environment and culture of decision making within the organization. Individuals of unique and persistent bad judgment clearly need to be removed from positions that leave the organization at risk. But far more important is to ensure that the commitment to the leadership qualities enumerated above are supported by the governing body and the executive leadership. Additionally, it is critical that those values are adequately communicated to the organization’s management and are part of the fabric of development and evaluation of management. The same values must be evident in the planning and decision-making processes that engage the governing body. Remedy for such judgment failure mistakes must involve the executive leadership in a process of reassertion of the values of the management as well as the organization’s expectations of the management.

Management mistakes resulting from ethical failures are perhaps the most difficult to confront. Such mistakes may be rooted in conflicts of interest, willful disregard for the welfare of individual patients, willful disregard for the reputation and well-being of the organization and its staff, or malicious acts that endanger the relationship of the organization to its community or its staff. Such
errors can only be addressed with the full involvement of the executive and the leadership of the governing body. These are the mistakes that require courage and certainty about the moral imperative of unequivocal commitment to ethical behavior. Assurances must be made that the ethical issues are communicated with clarity and force, that standards of ethical behavior are clearly established in policy, and that those standards are adhered to without exception. A culture of recrimination-free reporting must be established to allow full participation in the commitment to ethical behavior. Finally, there can be no uncertainty here about the outcome of an ethical failure. Individuals at the root of such mistakes cannot continue within the organization.

When Is a Mistake Not a Mistake?

When is a mistake a good choice? When is a good choice a mistake? From the perspective of a healthcare system executive, it is frequently asserted that a manager who never makes a mistake is being too conservative in strategic and tactical decision making. The assertion is especially true when all options have elements of risk and reward associated with them. In the increasingly complicated world of healthcare systems, there are only rarely clear winning and losing choices. Good and bad courses of action come to be defined by nuances and hair-splitting distinctions.

Consider the situation of a home care manager who chooses to pursue a perfect record of never having a patient claim rejected by an insurer. There is
certainly virtue in wanting to be sure that the home care program is not inappropriately providing care for patients whose need is questionable and who may not meet the requirements for care set by their health plan. There is a certain propriety to wanting to ensure that scarce institutional resources are not extended without the expectation of payment. However, even apart from the “justice” issues of caring for patients without insurance, the clinical decision about when a patient may benefit from a home care service is not always black and white. Additionally, it is not always clear whether a payer will approve home care until after the care is provided. In the face of a “gray” area decision, should a manager self-limit the care offered or lean in favor of providing the service that may be beneficial, even with the possibility or probability of payment being rejected? Seeking and attaining a perfect no-rejection record probably means that patients who could have benefitted were denied the service in order to reduce the possibility of a rejection. Which decision is the error? How high a rejection rate is desirable (not merely acceptable) to optimize the benefit of service and the expectation of payment? How high a rejection rate is desirable (not merely acceptable) to optimize the benefit of total payments and the cost of rejections? In this case, the good choice might be to make the mistake to deliberately test the limits of payer rejection whenever a patient benefit seems apparent and accept the payers’ rejection of the decisions to deliver care, “titrating” for the optimal intersection of the ability to serve and the financial outcome.
For many of us, the prospect of pursuing a policy of encouraging deliberate individual “bad” decisions in order to achieve an aggregated better outcome is distressing. Yet, if all other choices limit patient well-being or if all other choices strain the relationships between institution and community, is such a gray-area decision genuinely a management mistake? Perhaps not always. Hofmann makes a solid point that “nothing counts as a mistake unless in some sense we could have done otherwise”—or should have done otherwise.

Nonetheless, some decisions will clearly be mistakes. Even with the understanding that mistakes are inevitable, that all mistakes are not evidence of the individual moral inadequacy of a leader, and that not all mistakes damage the integrity of an organization or its mission, leaders who make mistakes will suffer the angst of concern and self-doubt. The effective strategies lie in the Hofmann article’s closing recommendations. They are also the morally correct choices.

- Failing to reveal mistakes inevitably generates secondary adverse outcomes for an organization. The light of day is often the best cure for such concern. Having rigorous, open, objective, and rational management review processes is a great preventive mechanism for postmistake fears of recrimination.
- Remember that healthcare systems belong to the communities they serve. Governing bodies have an absolute right and a responsibility to know about and understand the challenging decisions that face management,
and someone must represent the community in this process. Open disclosure of goals, strategies, tactics, and critical issues provides a powerful basis for sharing the risks of making difficult decisions and for minimizing the impact of errors.

- Similarly, employed staff and medical staff members have a right and responsibility to know about the critical challenges that face their institution. Having a clear set of processes and standards through which critical decisions are made can help ensure that the commitment of the staff is more robust. With their fullest participation, management can maximize the potential for success of a risky decision. Additionally, their full awareness and participation can make disclosure and recovery from a management mistake more natural and more successful.

One might refer to these qualities as anticipative, consultative, and participative (Toomey 1996). They are the critical elements that define the culture and values of a strong healthcare organization. Morally managing errors relies precisely on nurturing the culture of ethical behavior and the strength of the organization.

REFERENCES