
From a Culture of Blame to a Culture of Safety

– The Role of Institutional Ethics Committees

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Institutional ethics committees are largely absent from the literature on patient safety, but if health service organizations are adequately to address medical error and patient safety, they must change internally from a “culture of blame” to a “culture of safety.” This paper (1) looks at the concept of organizational culture as it currently exists and its components (jobs, people, and situations); (2) describes the safety culture in other high risk industries and (3) makes concrete suggestions to the health service industry. In particular, the author suggests that the functions and roles of ethics committees (ethics education, policy review and development, and case consultation) lend themselves perfectly to the development of those organizational characteristics that would support the creation and maintenance of patient safety culture in the healthcare industry.

At first blush, the remedy for medical errors seems quite simple: Tell the truth. Healthcare professionals have an obligation to disclose harm-causing medical errors, because patients have a right to the truth as well as redress from harms they suffer as a consequence of medical error. But is this commonsensical remedy all that an institutional ethics committee can recommend? Perhaps this limited perception is the reason that institutional ethics committees are largely absent from the literature on patient safety.

Many risk managers, compliance officers, hospital administrators, and healthcare professionals either do not consider a role for institutional ethics committees in patient safety, or assume that ethics committees consult only on a case-by-case basis, and will simply recommend disclosure in instances of medical errors. Some ethics committee members may themselves believe that ethics committees have only this advice to offer their institutions on the matter of medical error.

Of course, the remedy for medical errors is far from simple. The occurrence of medical errors involves a complex web of multiple factors.

Human misstep is certainly one such factor, but not the only one. Healthcare professionals are on the front lines in the defense against medical errors, but the changes that are needed to reduce medical errors and enhance patient safety are systemic in nature. In this paper, I argue that, if health service organizations are adequately to address medical error and patient safety, they must change internally from a “culture of blame” to a “culture of safety.”

I begin by providing an analysis of the concept of organizational culture as it currently exists. This discussion is necessary to set the terms for a change toward a culture of safety. It also establishes the basis for a consideration of the “culture of blame,” so prevalent in contemporary healthcare delivery. Suggestions for transitioning from a culture of blame to a safety culture, including a sketch of the ways ethics committees can help, form my conclusion.

The Concept of Organizational Culture

Organizational culture is a concept often used to describe shared corporate values that affect and influence employees’ attitudes and behaviors. For

example, Deal and Kennedy (1982) describe it as "the way we do things around here." Although no universal definition exists, academics and social scientists tend to define corporate culture as a set of common behaviors, beliefs, attitudes, and values regarding organizational goals, functions, and procedures that characterize particular organizations. Corporate culture identifies the way people think and behave in relation to the corporate body, its function or purpose.

At the same time, however, scholars recognize that corporate culture is not homogenous. The way individuals think, feel, perceive, and act in relation to the corporate body varies from division to division, department to department, team to team, and from individual to individual. In many organizations, a strong dominant culture pervades throughout different departments. In other organizations, however, the culture is far from uniform. Different subcultures emerge from functional groups, hierarchical levels, and

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organizational roles, with very few commonly held values, beliefs, attitudes, or behaviors shared by all employees. Differing subcultures, however, serve a useful function. A diversity of perspectives and interpretations can be a valuable resource for dealing with emerging problems that are systemic in nature.

Very few models of organizational culture appear in the literature. Most authors adopt either a functionalist account (e.g., Schein 1985), or a variant of an "interpretative view" of organizational culture (e.g., Johnson 1992). A comparison of the two models establishes the parameters for an analysis of safety culture. On a functionalist account, safety culture is a result of the underlying assumptions or the core purpose of an organiza-

tion. On the "interpretative view," safety culture is an emergent property of social groupings in the workplace and an organization's stakeholders.

Functionalist Models

Schein (1985) analyzes organizational culture as a relationship among three layers or levels: (1) core underlying assumptions or purpose; (2) beliefs and values; and (3) behaviors and artifacts. The relation of each level to the others is both linear and causal.

Corporate policies, management structures, and control systems express the underlying assumptions or purpose of an organization. An organization's purpose, in turn, predetermines or conditions the publicly declared beliefs and values of management and staff: level one causes or conditions level two. Management and staff realize these corporate beliefs and values in particular attitudes. Employee attitudes, in turn, determine or condition specific behaviors and artifacts: level two causes or conditions level three. Since level two conditions level three and level one conditions level two, the core underlying assumptions or purposes of an organization ultimately determine employee behaviors and the production of organizational, cultural artifacts.

In the aviation industry, for example, "zero tolerance" of accidents is an underlying assumption or purpose of organizations. Corporate policies, management structures, and control systems express this underlying purpose, which, in turn, determines the beliefs and values of employees about the importance of safety in air travel. Management and staff then realize these corporate beliefs and values as particular attitudes to aviation safety and employee attitudes about safety begin to determine or condition specific behaviors and artifacts. Organizational members express these attitudes either through safety inspections, or as accidents and near misses. Safety posters and brochures are artifacts that exemplify employees' attitudes. Thus, the underlying assumption of "zero tolerance" ultimately determines or conditions employee behaviors and cultural artifacts.

Interpretative Models — Johnson's Culture Web

Gerry Johnson (1992) juxtaposes the functionalist model of organizational culture to his own "interpretive" view. Although he agrees with Schein's three-layered analysis, he also thinks that the Schein's model fails to account for the dynamic nature of organizational culture. Functionalist approaches give the appearance of a linear sequence of cause and effect: core purpose dictates employees' beliefs and values, which in turn dictate behaviors and artifacts that reflect core purpose. Johnson provides ample evidence to support his claim that this account is simplistic and reductive. He notes as a counterexample that changes in employees' behavior often produce changes in their attitudes toward work. Moreover, changes in behaviors and attitudes can also lead to changes in an organization's underlying control systems and management structures.

Johnson offers a "culture web" model of organizational culture. This model also consists of a triad: a dominant paradigm, control systems and structure (underlying assumptions or purpose); beliefs and values (personal); and power relationships, stories, symbols, rituals, and routines (behaviors and artifacts). In Johnson's critique of functionalism, organizational culture is not simply a result of core purpose, but an emergent property of the beliefs and values of a variety of stakeholders. Normative beliefs and values are both created by, and revealed to, organization stakeholders within dynamic reciprocal relationships. Thus, organizational culture consists of reciprocal relations among

- stakeholders' perceptions of, and attitudes toward, an organization's core purpose;
- stakeholders' day-to-day behavior within power relationships; and
- the presence and quality of control systems to support stakeholders' attitudes and behaviors.

On Johnson's interpretive view, "zero tolerance" of accidents in the aviation industry is less a result of the purpose or goals of managerial strategies

than an emergent property of the values, attitudes, and beliefs of social groupings in the workplace and among stakeholders in the industry. For Johnson, zero tolerance as a goal "emerges" in the workplace from the values, attitudes, beliefs, and patterns of behavior among aviation industry stakeholders. Thus, zero tolerance is an emergent property that consists of reciprocal relations among (1) stakeholder perceptions of, and attitudes toward, the feasibility of zero tolerance; (2) stakeholders' day-to-day behavior toward this goal within power relationships; and

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(3) the presence and quality of control systems to support stakeholders' attitudes and behaviors toward aviation safety.

The two models of organizational culture are not necessarily mutually exclusive. For example, Dominic Cooper (1994) argues that both the functionalist and interpretive views are commensurate. He attempts to integrate the two models on the assumption that managerial functionalist strategies emerge within interpretive contexts.

On this reading, organizational culture is a "product" that emerges from the values, attitudes, competencies, and patterns of behavior of social groupings in the workplace and among the

organization's stakeholders. The functionalist view is correct because, as a "product," culture is a result of goal-directed behavior, or purpose. The interpretive view is also correct because goal-directed behavior, or purpose, is an emergent property created by social groupings within the workplace and among the organization's stakeholders.

Cooper thus synthesizes Schein's and Johnson's models by showing that organizational culture is a result of goal-directed behavior in the context of dynamic reciprocal relationships among the three levels of organizational culture: (1) the personal (values, beliefs, attitudes); (2) the behavioral (competencies, patterns of behavior); and (3) the situational (organization systems and subsystems). He thus defines organizational culture as the product of multiple goal-directed interactions among people (personal), jobs (behavioral), and systems (situational).

Toward a Definition of Safety Culture

The term "safety culture" first appeared in a report on the Chernobyl disaster prepared by the International Nuclear Safety Advisory Group (1988). The concept has since gained worldwide currency in several industries. It is used loosely to describe an institutional atmosphere or climate in which safety is understood to be the number one priority. In high-risk industries, such as nuclear power, chemical production, and aviation, industry leaders consider safety the dominant characteristic of corporate culture. In other industries, such as the automotive industry, safety is a subcomponent of the larger corporate culture. As a subcomponent, the concept refers to individual, job, and organizational features that affect and influence health and safety.

A widely used definition of safety culture comes from the British Health and Safety Commission (1993). This commission defined safety culture in relation to the nuclear power industry as

The product of individual and group values, attitudes, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's

health and safety programs. . . . Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.

Individuals understand this definition in different ways depending on their model of analysis. For example, a functionalist account of organizational culture understands the existence of safety culture in the nuclear power industry as a direct result of the industry's purpose, which determines the managers and employees' preferences. Thus, functionalist managerial strategies for a safety

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culture in the nuclear power industry are a direct consequence of the industry's goal of zero tolerance for nuclear accidents. On an "interpretive view," a safety culture "emerges" in the nuclear power industry from the values, attitudes, beliefs, and patterns of behavior of social groupings in the workplace, and among industry stakeholders. It is less a result of managerial purpose or goals than an emergent property of stakeholders and workers' values, attitudes, and beliefs.

Cooper (1994) argues that the Health and Safety Commission's definition of safety culture supports his view that the functionalist and interpretive accounts of organizational culture are compatible. He draws attention to the fact that the Commission defines safety culture as a "product," and not simply as an institutional climate or

aggregation of individuals' attitudes and perceptions. In effect, the Commission recognizes that, as a "product," safety culture in the nuclear power industry is a managerial functionalist strategy that emerges from the "values, attitudes, competencies, [and] patterns of behavior" of stakeholders within dynamic reciprocal relationships premised on "mutual trust." Management's goal-directed behavior of zero tolerance is thus an emergent property created by social groupings within the workplace and among industry stakeholders.

Occupational health and safety experts build on this definition in attempting to define the "product" and clarify what a safety culture should look like in an organization. The definition of safety culture as a product serves a number of purposes. First, a definition helps to determine the functional strategies that would be required to develop the "product." Second, when we

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understand safety culture as a product, we develop a better sense of how to measure the degree to which an organization has a "good" safety culture. Outcome measures, in turn, counteract unsystematic and fragmented approaches to safety culture.

Locke and Latham (1990) define the product of a safety culture as "that observable degree of effort to which all organizational members direct their attention and actions toward improving safety on a daily basis." This definition builds on the three essential ingredients of safety culture: (1) personal values, beliefs, and attitudes; (2)

behavioral competencies or patterns of behavior; and (3) the situational context of organizational systems and subsystems. Personal, behavioral, and situational elements combine to determine a safety culture "product."

Locke and Latham (1990) further distinguish the organizational characteristics that create the product of safety culture:

- ensuring that organizational members share the same ideas and beliefs about risks, accidents, and injuries;
- increasing employees' commitment to safety;
- ensuring that safety issues receive the attention warranted by their significance;
- producing behavioral norms;
- reducing accidents and injuries; and
- determining the style and proficiency of an organization's systems and subsystems.

They also note that each of these elements can be viewed both as a subgoal that helps an organization achieve its superordinate goal of safety culture, and as a goal achievement or consequence that emerges from the creation of safety culture. Thus, the creation of safety culture is achieved by setting a superordinate goal that can be reached by dividing the task into a series of subgoals intended to direct employees' actions toward safety.

Safety culture is, then, the product of multiple goal-directed interactions among people (personal), jobs (behavioral), and the organization (situational). It emerges from the dynamic reciprocal relationships among (1) stakeholders' perceptions of, and attitudes toward, the realization of the organization's goal of safety; (2) stakeholders' day to day goal-directed behavior toward this end; and (3) the presence and quality of organizational systems and subsystems to support the goal-directed behaviors.

Once we have delimited the three different levels of analysis of a safety culture, we can then

examine each level individually, or in relation to the other two levels. For example, Cooper (1997) defines the personal level of safety culture as the "safety climate dimension," the behavioral level as the "behavioral dimension," and the situational level as the "safety management dimension" of a safety culture. The "safety climate" encompasses subjective internal, psychological factors of safety culture; "safety behavior" encompasses the observable day-to-day safety-related behaviors; and "safety management" encompasses objective safety-oriented systems and subsystems.

Each dimension of safety culture, in turn, has its own unique characteristics. For example, a "safety climate" is dependent upon employees' personal commitment to safety, their safety knowledge, their personal involvement in decisions, and their personal commitment to the organization, among other things. "Safety behavior" depends in part on team work, task complexity, task strategies, and one's work environment. "Safety management" depends on management commitment, management actions, communications, the allocation of resources, strategic planning, policy development, standards, feedback, and monitoring.

In sum, the essential ingredients of a safety culture include people, jobs, and systems. Organizations with an interest in safety must attend to each level. If, for example, an organization simply tries to change employees' attitudes about safety without looking at organizational systems or employees' behaviors, nothing much will change. In Cooper's words (1997), the dimensions of safety climate, safety behavior, and safety management are integral in the creation of a culture of safety.

Elements of a Culture of Blame

Schein, Johnson, Cooper, and Locke and Latham provide a lens by which to examine the healthcare industry and its traditional institutional response to patient safety. First, we will characterize this response in broad terms; then we will address obvious weaknesses, and sketch ways in which ethics committees can help promote and sustain a culture of patient safety.

A cursory review of the literature shows that patient injuries due to medical errors are a huge problem in the healthcare industry, particularly those due to medication errors. The report *To Err Is Human* cites two separate studies in concluding that perhaps as many as 44,000 to 98,000 patients die annually due to medical errors — more than from highway accidents, breast cancer, or AIDS combined (Kohn, Corrigan, and Donaldson 2000). Even if we accept the lower estimate, deaths

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resulting from medical error still exceed the number of deaths attributable to the eighth leading cause of death. Though the data are old and subject to manipulation, we cannot dispute the fact of patient injuries and deaths from medical errors. Whatever the actual rate turns out to be, clearly the injury rate in the healthcare industry compares unfavorably with other industries.

We can also agree on the traditional institutional response to patient safety. At the risk of generalization, we can safely assume that patient safety has *not* been a top priority in most health service organizations. In other high-risk industries, such as aviation and nuclear power, industry leaders consider safety to be the dominant characteristic of organizational culture, and in industries such as manufacturing, safety is a subcomponent of organizational culture. At best, we can assume that patient safety has been a subcomponent of the organizational culture in most healthcare facilities and, as such, generally has not been

addressed in a systematic and comprehensive fashion. Given that modern healthcare delivery “presents the most complex safety challenge of any activity on earth,” we ought to expect that a more fitting response would make patient safety a dominant characteristic of organizational culture in healthcare (Leape et al. 1998).

Cooper’s triadic model of the personal, the behavioral, and the situational levels of organizational cultural can help us analyze and evaluate patient safety in the healthcare industry.

First, absent statistically valid studies and hard data, we can nevertheless make some preliminary observations about the personal, behavioral, and situational levels of patient safety culture in the healthcare industry. Authors on the subject have almost uniformly concluded that healthcare has failed to design systems for patient safety, relying instead on requiring individual error-free performance enforced by punishment. There is an “entrenched belief” in the industry in the effectiveness of blame and punishment for error prevention, a conviction reinforced by highly punitive legal and regulatory systems and the public media. The industry relies almost exclusively on the threat of legal, financial, or disciplinary penalties to ensure patient safety and operates on the assumption that most patient injuries result from bad behavior (e.g., incompetence, negligence, or corporate greed). In short, a culture of blame pervades healthcare.

Yet, as we noted in the previous section of this paper, if organizations try to change employees’ attitudes without considering either jobs or organizational features, they will likely fail in their efforts to address safety issues. Or, again, if organizations disregard employees’ behaviors or attitudes about safety, they will likely fail in their efforts to change organizational systems. Each level of the personal, the behavioral, and the situational is essential in the creation of a safety culture.

Second, a survey of the literature shows that health service organizations have focused narrowly on the personal level to the complete

neglect of the behavioral and situational. Cooper’s analysis of the dimensions of safety culture also helps us probe more deeply the elements of this culture of blame. Recall that Cooper defines the personal level of safety culture as the safety climate dimension, the behavioral level as the behavioral dimension, and the situational level as the safety management dimension of a safety culture. The safety climate encompasses subjective internal, psychological factors of safety culture; safety behavior encompasses the observable day-to-day safety related behaviors; and safety management encompasses objective safety-oriented systems and subsystems.

Health service organizations have largely ignored both the safety behavior and the safety management dimensions of safety culture. With regard to the safety behavior dimension, organizations have failed to integrate patient safety into team work, task strategies, task complexity, and the work environment. With regard to the safety management dimension, health service organizations have also failed to integrate patient safety into management commitment, management actions, communications, allocations of resources, strategic planning, policy development, standards, feedback mechanisms, and monitoring functions.

Not only has the healthcare industry virtually ignored the safety behavior and safety management dimensions of safety culture; it has also acted to undermine the safety climate dimension. Safety climate depends, for example, on employees’ personal commitment to safety, their personal involvement in decisions about safety, their safety knowledge, and their personal commitment to the organization. The literature suggests that administrators have used a combination of force and manipulation to coerce healthcare professionals into “error-free” performance.

Experience in other industries confirms that this approach demoralizes staff; in fact, it produces the exact opposite outcome from the intention. Blame and punishment provide strong incentives for people to hide their mistakes, which prevents the recognition, analysis, and correction of underlying

causes. Rather than improving patient safety, blame and punishment make reducing errors much more difficult. If health service organizations continue to ignore the safety behavior and safety management dimensions of safety culture, and undermine the safety climate dimension, they will fail in their efforts adequately to address patient safety.

Toward a Culture of Patient Safety

Cooper's analysis of safety culture helps us understand the culture of blame that pervades healthcare. It can also provide guiding principles for organizational transformation to a culture of patient safety. The promotion of patient safety culture hinges on the development of the patient safety climate, patient safety behavior, and

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patient safety management dimensions within the healthcare industry. The patient safety climate dimension depends, for example, on the personal commitment of healthcare professionals and staff to patient safety, their personal involvement in decisions about patient safety, their patient safety knowledge, and their personal commitment to their organizations. The patient safety behavior dimension, on the other hand, depends on team work, task strategies, task complexity, and work environment. Finally, the patient safety management dimension depends on management commitment, management actions, communica-

tions, allocation of resources, strategic planning, policy development, standards, feedback, and monitoring.

In short, a patient safety culture must encompass subjective internal, psychological factors, observable day-to-day patient safety related behaviors, and objective patient safety-oriented systems and subsystems. How may ethics committees contribute to this organizational transformation toward a patient safety culture? Here we can use Locke and Latham's analysis of the organizational characteristics that help create or enhance safety culture to derive some ideas about how ethics committees can promote these organizational characteristics in a healthcare environment. Characteristics include

- (1) ensuring that organizational members share similar ideas and beliefs about patientsafety;
- (2) increasing the commitment of healthcare professionals and staff to patient safety;
- (3) ensuring that patient safety issues receive attention from healthcare administrators;
- (4) producing behavioral norms around patient safety;
- (5) reducing medical errors and injuries to patients; and
- (6) determining the style and proficiency of an organization's systems and subsystems to support the patient safety climate and patient safety behavior dimensions of patient safety culture.

Based on Locke and Latham's recommendations, ethics committee members ought to view each of these elements both as subgoals that would help their organization achieve its superordinate goal of a patient safety culture and as goal achievements or consequences that emerge from the creation of a patient safety culture. Thus, the creation of patient safety culture depends on setting a superordinate goal of patient safety that can be achieved by dividing the task into a series of subgoals intended to direct everyone's actions toward the creation of patient safety culture.

Ethics committees have multidisciplinary resources at their disposal that could make an enormous contribution toward the development of each of these organizational characteristics in their institutions. In general, ethics committees perform three functions and roles: ethics education, policy review and development, and both retrospective and prospective case consultation.

Ethics committees could use these functions and roles in support of patient safety culture.

Through ethics education, ethics committees can influence management commitment, management actions, communications, allocation of resources, and strategic planning.

Ethics committees could, for example, use their educational function and role to influence the patient safety climate dimension within their organizations. A patient safety climate depends on shared beliefs, values, and attitudes regarding patient safety. Through ethics education, ethics committees can help shape a self-sustaining image of patient safety among administrators, healthcare professionals, and staff. Shared beliefs, values, and attitudes about the importance of patient safety would then foster a commitment in their organizations to a patient safety culture.

As we have seen, when an organization focuses only on the personal level, it actually undermines its patient safety climate. Health service organizations have relied primarily on discipline to change people's attitudes and behaviors. But discipline is an inefficient means by which to manage change in values, beliefs, and attitudes, or in unsafe behavior. The literature on safety suggests that the best way to change safety attitudes and unsafe behavior is to focus on safety behavior. This focus entails adopting a collaborative, problem-solving approach involving administrators, healthcare professionals, and staff to identify critical sets

of safe and unsafe behavior. Ethics committees could use their multidisciplinary case consultation function and role to help develop "safety inventories" that staff could then use to monitor patient safety behavior.

For example, ethics committee members are well suited to draw on the resources of healthcare professionals from different disciplines to manage a thorough ethical analysis of a case involving a medication error. A thorough ethical analysis of the error depends on understanding how each level, the personal (people), behavioral (jobs), and situational (systems), contributed to the unanticipated outcome. In a case consultation, committee members would learn from best practices how to address unsafe behavior in the delivery of medications. By identifying unsafe behavior, the committee can help the organization develop a patient safety inventory for medications, or a critical set of safe behaviors.

At the very least, the ethics committee can interact with other personnel or committees in charge of patient safety to help them reinforce a safety inventory for medications. Healthcare professionals and staff may then use the safety inventory to monitor ongoing safety behavior. Based on the results of peer monitoring, teams of professionals and staff would then set their own safety improvement targets in a participatory environment. In its case consultation, then, the

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ethics committee would encourage cooperation, involvement, and better communications to improve the patient safety climate and patient safety behavior.

A patient safety climate will ultimately depend on the perceptions and beliefs of healthcare professionals and staff about the organization's patient safety management practices. According to Cooper (1997), organizations ought to adopt a holistic approach to the development of the safety management dimension of safety culture. A safety management system depends on many activities with diffuse responsibility. It therefore requires an integrated approach for managing safety risks, ongoing safety performance, and compliance.

First, an organization should develop its safety management practices based on management commitment, management action, communications, strategic planning, policy development and procedures that provide internal consistency and harmonization of functions.

Second, an organization should audit the system to ensure the reliability, efficiency, and effectiveness of its planning, policy develop-

Ethics committees ought to be at the very center of organizational transformation to patient safety culture. Ethics committee members usually represent diverse subcultures within their institutions and they have multidisciplinary resources at their disposal.

ment, implementation, and monitoring of safety performance. Finally, an organization ought to perceive the development of a safety management system as a way to generate awareness, understanding, motivation, and commitment on the part of all personnel.

Ethics committees could use both their ethics education and, in particular, their policy review and development functions and roles to influence the development, implementation, and

monitoring of their organizations' patient safety management system. Through ethics education, ethics committees can influence management commitment, management actions, communications, allocation of resources, and strategic planning. Through policy development, ethics committees can influence the development of patient safety standards. By helping to develop standards, ethics committees can thereby help their organizations monitor and review inter-related safety activities.

Conclusion

Organizational culture is complex, and the cultures of health service organizations are especially so. While in many healthcare facilities, a strong dominant culture prevails throughout and across different departments, culture is far from uniform in most organizations. The way administrators, healthcare professionals and staff think, feel, perceive, and act in relation to the corporate body varies from division to division, department to department, team to team, and from individual to individual. Different subcultures emerge from functional groups, hierarchical levels, and organizational roles, with very few values, beliefs, attitudes, or behaviors shared by all stakeholders. Differing subcultures, however, can serve a useful purpose in organizational transformation. A diversity of perspectives and interpretations can be a valuable resource for dealing with emerging problems that are systemic in nature.

As the safety literature shows, the creation and maintenance of safety culture is also multidimensional, and depends on dynamic reciprocal relationships among multiple stakeholders premised on "mutual trust." Organizations with an interest in safety must attend to each dimension. Experience in other industries demonstrates that, if health service organizations try simply to change employees' attitudes about safety, or to mandate only organizational systems change, or seek changes only in the behavior of healthcare professionals and staff, failure is a probable

outcome. The dimensions of safety climate, safety behavior, and safety management are integral to the creation of a culture of safety.

It appears at first blush that ethics committees can only offer their institutions a recommendation to tell the truth in the event of medical error. In fact, ethics committees ought to be at the very center of organizational transformation to patient safety culture. Ethics committee members usually represent diverse subcultures within their institutions and they have multidisciplinary resources at their disposal, which may be used to help their organizations address, not only the subjective internal, psychological factors of patient safety, but also the observable day-to-day patient safety related behaviors, and the objective patient safety-oriented systems and subsystems. The functions and roles of ethics education, policy review and development, and case consultation lend themselves perfectly to the development of those organizational characteristics that would support the creation and maintenance of patient safety culture in the healthcare industry.

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