

# Preface

Keith Ramstead was a British cardiothoracic surgeon who moved to New Zealand. There, three patients died during or immediately after his operations, and he was charged with manslaughter.<sup>1</sup> Not long before, a professional college had pointed to serious deficiencies in the surgeon's work and found that seven of his cases had been managed incompetently. The report found its way to the police, which subsequently investigated the cases. This in turn led to the criminal prosecution against Ramstead.

## From Acts of God to Culpable Mismanagement of Risk

We have not always looked at three dead patients as evidence of a possible crime, or as any form of reprehensible behavior. Turning to human error as explanation for an accident, and making it into a culpable act or a crime, is only a very recent way of dealing with failure. In fact, the whole idea of an "accident" is relatively modern.<sup>2</sup> Up until the scientific revolution in the seventeenth century, we apparently had no need for a concept like "accident." Religion and superstition supplied ample explanatory models for things that went wrong. We called it fate, predestination, God's will, witchcraft, taboo-breaking. Where misfortune was going to hit was—as far as mortal humans were concerned—random, uncontrollable.

It stayed this way for the next couple of hundred years, though ever fewer people bought into the idea that accidents had divine or demonic incitement behind them. In the early twentieth century, we began to see accidents as unfortunate but otherwise meaningless coincidences of space and time. As random physical events, though, we still did not consider accidents worthy of study. And we judged attempts to predict and prevent accidents as largely useless.

Over the last 30 years, however, this interpretation of accidents has shifted dramatically. Startling failures such as the Three Mile Island nuclear accident in 1973 and the collision of two jumbo jets at Tenerife in 1977 moved accidents back onto the centerstage of our societies.

No longer do we see accidents as meaningless, uncontrollable events. On the contrary: accidents are evidence that a particular risk was not managed well enough. And behind that mismanagement, there was a person, or multiple people. Today, even though we use the word quite freely, we have actually drifted from the idea of “accident” altogether. We spend huge amounts of resources on formally investigating all large accidents. Why would we do that if accidents are random events, if they are meaningless coincidences (“really” accidents)? We could investigate meaninglessness all we want, but there would be nothing to discover, nothing to change. No, we expect experts to make accidents comprehensible. We want them to explain which risk factors were not controlled, where and when and by whom. Accidents are no longer accidents at all. They are failures of risk management.

Failures of risk management invite us to look for somebody who was responsible. If misfortune hits today, we really don’t see it as random or uncontrollable any longer. We often want to find out who didn’t do her or his job. And then we want to put the “accident” on their account.

## A Trend towards Criminalization

So the trend towards criminalizing human error, in a variety of fields of practice, is a relatively recent phenomenon. It has a lot of people worried, and understandably so. In Chapters 7, 8, 9, and 10 I will deal extensively with the problems of criminalization. For example, I will note how we delude ourselves that there should be consequences for operators or practitioners who “cross the line.” I will explain how we don’t realize that lines don’t just exist “out there,” ready to be crossed or obeyed, but that we—people—construct those lines, that we draw them differently every time, and that what matters is not *where* the line goes—but *who* gets to draw it.

Criminalization is only one bookend on a longer shelf of challenges with what we call “just culture.” A just culture is something very difficult to define, as “justice” is one of those essentially contested categories. We will never agree with each other about what justice means, or what is just versus what is unjust. Essentially contested means that the very essence, the very nature, of the concept is infinitely negotiable. But that does not mean that we cannot agree, or make some progress on, some very practical problems related to what we could call a just culture.

A very daily challenge for many people in safety-critical domains, for example, is simply to get practitioners to talk about safety problems, to send

in reports, to honestly disclose. Building up trust, and giving people a sense of ownership and participation in system safety improvement is difficult enough. I start with that in the very next chapter and continue in Chapters 3 and 4, pausing to zoom out onto a case that takes various angles at just culture in Chapter 2. In Chapters 5 and 6, I look at the effects of hindsight in determining culpability and how different constructions of error (as technical or normative) have quite different ramifications for what we wish to do about it. In Chapter 12, I take the problem of the division between old view and new view of human error head-on. If human error is a symptom of trouble deeper inside a system, then we can simply blame the system. But what happens with people's accountability then? Chapter 13 gives you some concrete steps to go forward with building a just culture.

## Different Interpretations, Different Countermeasures

To charge professionals like Keith Ramstead with a crime is just one possible response to failure. It is one possible interpretation of what went wrong and what should be done about it. As I try to indicate throughout the book, other ways are possible too, and not necessarily less valid:

- For example, one could see the three patients dying as an issue of cross-national transition: are procedures for doctors moving to Australia or New Zealand and integrating them in local practice adequate?
- And how are any cultural implications of practicing there systematically managed or monitored, if at all?
- We could see these deaths as a problem of access control to the profession: do different countries have different standards for who they would want as a surgeon, and who controls access, and how?
- It could also be seen as a problem of training or proficiency-checking: do surgeons submit to regular and systematic follow-up of critical skills, such as professional pilots do in a proficiency check every six months?
- We could also see it as an organizational problem: there was a lack of quality control procedures at the hospital, and Ramstead testified having no regular junior staff to help with operations, but was made to work with only medical students instead.
- Finally, we could interpret the problem as socio-political: what forces are behind the assignment of resources and oversight in care facilities outside the capital?

It may well be possible to write a compelling argument for each of these explanations of failure—each with a different repertoire of interpretations and countermeasures following from it. A crime gets punished away. Access and proficiency issues get controlled away. Training problems get educated away. Organizational issues get managed away. Political problems get elected or lobbied away.

This also has different implications for what we mean by accountability. If we see an act as a crime, then accountability means blaming and punishing somebody for it. Accountability in that case is backward-looking, retributive. If, instead, we see the act as an indication of an organizational, operational, technical, educational or political issue, then accountability can become forward-looking. The question becomes: what should we do about the problem and who should bear responsibility for implementing those changes?

The point is not that one interpretation is right and all the others wrong. The point is that multiple overlapping interpretations of the same act are always possible (and may even be necessary to capture its full complexity!). And all interpretations have different ramifications for what people and organizations think they should do to prevent recurrence.

Some interpretations, however, also have significant negative consequences for safety. They can eclipse or overshadow all other possible interpretations. The criminalization of human error seems to be doing exactly that. It creates many negative side-effects, while blotting out other possible ways forward. This is unfortunate and ultimately unnecessary. Unjust responses to failure, as I will argue in the last chapter, are not about bad performance. They are about bad relationships. And relationships can be managed. Just as nowadays we believe that risk can be managed.

## Notes

- 1 Skegg, P.D.G. (1998). Criminal prosecutions of negligent health professionals: The New Zealand experience. *Medical Law Review*, 6, 220–46.
- 2 Green, J. (2003). The ultimate challenge for risk technologies: Controlling the accidental. In: J. Summerton and B. Berner (eds), *Constructing risk and safety in technological practice*. London, UK: Routledge.