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Short report

On the prospects for a blame-free medical culture

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ABSTRACT

Official policy-making bodies and experts in medical error have called for a shift in perspective to a blame-free culture within medicine, predicated on the basis that errors are largely attributable to systems rather than individuals. However, little is known about how the lived experience of blame in medical care relates to prospects for such a shift. In this essay we explore the benefits and costs of blame in medical culture. Our observations are informed by our clinical experience and supported by interview data from a study in which 163 American physicians were interviewed about caring for a total of 66 dying patients in two institutions. We observe three ways in which blame is invoked: (1) self-blame, (2) blame of impersonal forces or the “system,” and (3) blame of others. Physicians articulate several important functions of blame: as a stimulus for learning and improvement; as a way to empathically allow physicians to forgive mistakes when others accept responsibility using self-blame; and as a way to achieve control over clinical outcomes. We argue that, since error is viewed as a personal failing and tends to evoke substantial self-blame, physicians do not tend to think of errors in a systems context. Given that physicians' ideology of self-blame is ingrained, accompanied by benefits, and limits a systems perspective on error, it may subvert attempts to establish a blame-free culture.

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The United States' Institute of Medicine (IOM), the United Kingdom's National Health Service (NHS), other official policy-making bodies, and experts in medical error have championed the need for a “blame-free culture” in medicine, with systems for detecting and reporting errors similar to the aviation and other industries (Dickey, Damiano, & Ungerleider, 2003; Kohn, Corrigan, & Donaldson, 2000; Leape et al., 1998; Runciman, Merry, & Tito, 2003; Wise, 2001). It is commonly argued that the best way to uncover and reduce error is to promote a culture where no blame is ascribed to individual actors. Moreover, in this paradigm, most errors are viewed largely as system-based, as impossible to eradicate completely, and as infrequently traceable to truly negligent actions (Dickey et al., 2003; Kohn et al., 2000; Leape et al., 1998; Runciman et al., 2003; Wise, 2001). Although blame is left undefined by these organizations, it is seen as doing more harm than

good, as engendering feelings of inadequacy or fear of punishment, and as ultimately pushing analysis and recognition of mistakes underground and limiting opportunities for improvement (Gianetti, 2003; Meaney, 2004; Runciman et al., 2003). Nevertheless, blame is present in medical care, and it is unclear whether it can – or indeed should – be eliminated.

We define blame in accordance with Webster's Ninth New Collegiate Dictionary as, “responsibility for something believed to deserve censure.” Little is known about how the lived experience of blame in medical care relates to the prospects for a shift in perspective to a blame-free culture (Dickey et al., 2003; Kohn et al., 2000; Wise, 2001). It is clear, however, that an important component of the response to errors lies in the readiness of clinicians to ascribe blame to themselves and to others. In this essay, we explore the benefits and costs of blame in medical culture. We believe that blame serves important purposes and contributes to physicians' difficulty viewing error in a systems context. We argue, therefore, that the prospects for a blame-free culture in medicine are limited.

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Methods

Our observations are informed by our clinical experience as attending palliative care physicians often involved in the care of patients with unexpected outcomes, and as a medical student training in a teaching hospital environment. Our opinions are supported by our interpretation of interviews from 163 American physicians caring for 66 dying patients in two academic medical centers in the northeastern United States. As part of a larger study of physicians' emotional reactions to patient deaths, physician participants were enrolled by sampling patient deaths from the medical and intensive care services at each site between 1999 and 2001. Up to two patients per week were randomly selected through weekly chart review of decedents. From the 81 index patient deaths, interns, residents, and primary attending physicians caring for these patients were identified ($N = 251$). A total of 246 physicians remembered caring for the index patients and 196 (80%) agreed to be interviewed. A subset of 33 participants were asked only to complete closed-ended items relating to the index patient death, producing 163 interviews regarding 66 patients. Informed consent was obtained from all participants prior to the interview. The study was approved by the Institutional Review Board at both sites.

Each physician was interviewed in detail about the index patient death. In addition, each respondent was interviewed about the most emotionally powerful death the physician could remember. The interview was semi-structured, consisting in part of open-ended questions designed to allow physicians to describe the care they delivered to patients who died. Our interpretations are based on themes identified and coded from a subsample of interviews with the 75 physicians at one site selected to build the qualitative coding schemas using *grounded theory* (Glaser & Strauss, 1967; Strauss, 1987). Of this subset, 27 (36%) were attending physicians, 23 (31%) were residents and 25 (33%) were interns. Physicians at the two sites were compared, and no statistically significant differences were found in quantitative or demographic measures. In addition, a comparison reading of 15 selected cases from the other site showed similar narrative themes (Good et al., 2004). As we read and coded these data for several related papers (Good et al., 2004; Jackson et al., 2005; Redinbaugh et al., 2003; Ruopp et al., 2005), in which clinicians' efforts to evaluate responsibility were examined, we became interested in how clinicians spoke about moral failing and agency. The way that blame was discussed mirrored our training and experience and suggests important professional values. Those interviews with codes involving error, iatrogenesis, complications, and "other screw ups" were selected for close reading for this commentary. More details about sample development are found in prior papers analyzing other aspects of physicians' responses to terminal illness (Good et al., 2004; Jackson et al., 2005; Redinbaugh et al., 2003; Ruopp et al., 2005).

Results

Types of blame

In order to assess the risks and benefits of blame, it is necessary to discuss the types of blame. We observe three ways in which blame is invoked: (1) self-blame, (2) blame of impersonal forces or the "system," and (3) blame of others. We believe that physicians most forcefully blame themselves, rather than the system or others, for perceived errors and bad outcomes (Ruopp et al., 2005). Blame is ascribed to the self for all kinds of occurrences, with unexpected outcomes inviting particularly close scrutiny of one's own actions (Bosk, 1979; Jackson et al., 2005). Physicians seem less willing to blame systems problems or impersonal forces for errors.

If gross violations of a recognized standard of care have occurred, they may – reluctantly – blame colleagues.

The work of Wu, Folkman, McPhee, and Lo (1991) and other authors has demonstrated a high prevalence of physician acceptance of responsibility as well as guilt (Engel, Rosenthal, & Sutcliffe, 2006; Gabbard, 1985; Newman, 1996). Together, responsibility and the self-censure suggested by guilt imply self-blame. Physicians' self-blame extends well beyond admitting to minor errors; physicians may feel they have caused the deaths of patients. One attending physician we interviewed recalls: "It was a disaster. This girl had died, and I saw that I had missed that she was ischemic. I felt responsible for her dying. It's less emotional now, after 10 years, but it's still there." While many of the physicians we interviewed confronted and rebuked their actions, others implicated themselves in bad outcomes for which they do not appear to bear primary responsibility. An example of this propensity towards self-blame is the presence of guilt for decisions or actions in which physicians – especially early in their training – have little or no input. Physicians' ability to blame themselves also finds expression in their apparent sense of collective guilt for errors committed by others on their team or in their institution. When physicians use the pronoun "we" while discussing mistakes, this suggests a willingness to include themselves in the sometimes-faulty decisions and actions of others, a form of identification with colleagues and acceptance of blame for which personal responsibility is not clearly assigned. This diffusion of blame, we believe, may represent an effort to assume control over bad outcomes by conceptualizing them as related to a mistake, rather than the randomness and inherent risk that pervade medicine.

While physicians also place responsibility for perceived errors on impersonal forces, such as lack of time, difficult pathologies, and transfer of care, we find that such attribution usually lacks the condemnation, censure and emotional intensity of other types of blame. In our experience, physicians' statements about the blameworthiness of the system are noteworthy for their relative lack of emotional content. One physician we interviewed blamed the academic calendar with the simple explanation: "It was July." Other statements serve to distance medical technology from human agency as impersonal forces are blamed: "The preliminary reading had not been accurate." We feel that the reluctance of physicians to muster anger at the "system" seems to indicate their passive acceptance of the way the health care system operates as well as their own beliefs in bad outcomes as avoidable with good medical practice. Physicians seem to more commonly reserve their emotional response to perceived errors for themselves.

We observe that it is difficult for physicians to express outright anger at specific colleagues, and when physicians do blame others, they do so as a last resort. We see evidence of anger directed at others when a clear violation of a standard of care is perceived, but not for other types of errors, which are rarely discussed in a context of blame (Bosk, 1979). However, even such (limited) anger may be dampened, and physicians often offer some type of explanation or forgiveness for errors committed by others. In the following example, a physician challenges the logic of another medical team and then reconsiders this blame, going so far as to include his own team in the guilt associated with the unfortunate outcome of the patient:

It was just a questionable judgment call... There was no way to predict she would have had it. So we can't fault them. It's just like Monday morning quarterbacking. It's like "Aha! This is exactly why you shouldn't have done it." But it's easy for us to say because we know what happened to her. Nonetheless, we still felt very guilty.

Attention to the phenomenon of blaming other professionals or impersonal forces is limited (Bosk, 1979; Goldberg, Kuhn, Andrew,

& Thomas, 2002; Newman, 1996; Wu, 2000). Several studies find that physicians who have made errors anticipate or report shame or reprimand from their colleagues, but few studies discuss how professionals view the errors of others (Christensen, Levinson, & Dunn, 1992; Gallagher, Waterman, Ebers, Fraser, & Levinson, 2003; Goldberg et al., 2002; Newman, 1996). Other studies have found that physicians were tolerant of colleagues' mistakes and unlikely to blame them (Christensen et al., 1992; Mizrahi, 1984). We observe that blaming others is indeed uncommon, and as we will discuss, is often coupled with empathy or forgiveness.

Ambivalence

Many physicians express both repudiation and acceptance of guilt. This ambivalence suggests uncertainty and conflict in physicians' attributions, and in their perceptions of personal responsibility (Mizrahi, 1984). While recognizing, at least intellectually, that errors and bad outcomes occur regularly in medicine, our observations suggest that it is sometimes unclear when an error has taken place. Physicians appear to struggle to tease out, even for themselves, when a patient does poorly because of an error caused by themselves or others, or because of the vagaries and uncertainties of medical practice or the system. One intern denied and then endorsed guilt recalling her experience as a third-year medical student, despite her limited role on the team:

I had no idea what was going on. I never felt guilty because I knew that I was a 3rd year student and I knew there were five people above me who were really taking care of her.... I was definitely feeling guilty and worried that I had somehow impacted that, even though I knew, logically, that I was not to blame.

This ambivalence may also have the "benefit" to physicians of obscuring or mitigating some of the guilt and self-blame to which they subject themselves. In addition, the sense of responsibility, even if not warranted, may stimulate learning and future efforts to prevent similar bad outcomes.

Benefits and costs of blame

The prevalence of blame that we observe leads us to consider the purposes it serves in education, self-improvement and medical culture. It is true that blame may be detrimental for the reasons outlined by policy groups and for the psychological consequences it may engender. Mistakes and errors can elicit powerful emotions of guilt, fear, remorse, embarrassment, anger, shame, humiliation, or inadequacy. Prior work has considered the effects of errors on clinicians themselves, both as members of an imperfect and "dangerous" profession, and as individuals whose mistakes have harmed patients (Christensen et al., 1992; Engel et al., 2006; Gallagher et al., 2003; Goldberg et al., 2002; Hilfiker, 1984; Levinson & Dunn, 1989; Mizrahi, 1984; Newman, 1996; Wears & Wu, 2002; West et al., 2006; Wu et al., 1991; Wu, Folkman, McPhee, & Lo, 1993). The long-term effects of making mistakes may include symptoms of depression and burnout (Gallagher et al., 2003; Giannetti, 2003; Goldberg et al., 2002; Hilfiker, 1984; Wears & Wu, 2002; West et al., 2006; Yee, 2002). Yet few have discussed the possible utility of blame, although Wu et al. (1991) found that physicians who accepted responsibility for mistakes were more likely to report improvements in their practice. The physicians we interviewed articulated several important functions of blame. Woven throughout the following discussion, which reveals the benefits of blame, is also evidence of the psychological costs of blame. Ambiguity and ambivalence about blame are also demonstrated here. This may help physicians titrate their own levels of

distress to tolerable levels – if the situation is ambiguous, perhaps less blame is indicated.

Blame can be useful as a stimulus for learning and improvement, corroborating the findings of Wu et al. (1991) and Engel et al. (2006). Medicine is a learning culture in which everyone makes mistakes, and from which everyone is expected to learn (Bosk, 1979). Within a context of blame, physicians' discussions of perceived errors are often linked to a clinical lesson, and the declaration that their future skills and patients will benefit from this unfortunately guilty knowledge:

The resident was very supportive, but I couldn't get over that I had failed to do this, that I led the patient to death. [The chief resident] chalked it up as a learning experience, given the fact that I was ruminating over it, the fact that I was thinking seriously about it. You learn by mistakes, and unfortunately they are real mistakes and there are real consequences, but you can't ruminate over each mistake forever. You internalize it and it makes you a more careful physician, a better doctor.

We argue that self-blame can lead to strong empathy with fellow physicians, enabling supportive behavior and forgiveness for mistakes (Bosk, 1979; Christensen et al., 1992). Physicians we interviewed were aware of an interplay between lessons learned from blame and forgiveness:

One of your jobs as an ICU senior is supporting your fellow residents, in terms of evaluating what they did, what they could have done differently, and what they are going to do next time.... I try to make someone feel better about something that has happened without missing the learning point. You know you can't tell someone it's okay that they made a mistake, but you can certainly make them understand what the circumstances were and that they are never the only person involved.

In this case, the resident invokes the collective agency involved in the mistake in order to help his/her fellow residents find a balance between forgiveness and learning. As demonstrated above, one key to eliciting forgiveness and supportive behavior from colleagues is the acceptance of responsibility on the part of the person who made the error; self-blame is thus a critical component of receiving forgiveness from others (Bosk, 1979).

Blame, and especially self-blame, allows physicians to retain the belief that they are expert and powerful agents, capable of intervening against nature and helping patients, and that there are rules which, when followed, prevent bad outcomes. Blaming permits physicians to believe they exert a degree of personal control over outcomes, and that there may be a different outcome next time:

I allow it [self-blame] to happen because it's looking for absolution, or it's a punishment, hoping that you won't make a mistake again like that. I'd like to think his death may have prevented some catastrophe with someone in the future.

Since it seems unlikely that physicians will be willing to see medical successes merely as a product of the "system," we cannot expect them to see medical failures as the product of the system. Blame then, may allow physicians to feel pride and satisfaction, as well as guilt and self-recrimination. It may also foster careful practice in the future, with the expectation that diligence in following the rules will always protect the patient from poor outcomes.

Conclusion

Although the IOM's report *To Err is Human* concludes that "improving patient safety requires fixing the system, not fixing blame" (2000: 179), we believe that changing this culture will be

even more challenging than previously recognized because of how ingrained physician self-blame is as a response to perceived errors (Engel et al., 2006; Newman, 1996; Wu et al., 1991). We argue that there is less of a culture focused on fixing blame on others, and rather an overwhelming culture of blame directed inwards. Adopting a blame-free culture requires a systems perspective, but we believe that physicians tend not to think of errors in a systems context.

This is a sensibility that is supported both by our experience and by our analysis of the sentiments of the physicians we interviewed. We acknowledge these views may not be generalizable as they represent only two academic teaching hospitals and largely deal with blame in the context of death and dying. In addition, what people say in interviews may not reflect their actual beliefs or attitudes. However, as educators, we have seen this pattern of self-blame, admission to colleagues, receiving of empathy, and learning lessons as common occurrences throughout medical training. At the least, we worry about institutional attempts to change medical culture without more empirical data on the question of how doctors use and interpret blame, and how this affects their work.

Physicians typically believe both that they can personally help save patients' lives and also that they are a part of a profession that can do so. Encountering death or errors in patient care can threaten these foundational beliefs. It may be that it is easier for physicians to admit and deal with their own fallibility and to assume personal blame than to admit to the inherent shortcomings of their profession and to blame the system. Mistakes made by individual doctors are seen as avoidable and controllable with greater experience and knowledge, and the goals of our profession include improvement and greater human control. This process was described in Bosk's (1979) work, where he found that certain types of errors are permitted among surgical trainees in a controlled setting, in order to help trainees gain competence and clinical judgment. Attendings "control mistakes", and encourage examination of actions as evidence of trainees' commitment to learn. Attributing error to the system or the profession discounts physicians' control over clinical outcomes, and "medicine's tenacious commitment to individual, professional autonomy" (Leape & Berwick, 2005). This contrast between deciphering whether there is a specifically individual rather than broadly professional failing is reminiscent of Fox's (1957) classical work about uncertainty in medicine, where physicians must distinguish whether their uncertainty arises from their own limitations or the limitations of the field as a whole (Fox, 1957; Mizrahi, 1984). Indeed, within Light's (1979) framework in which techniques such as mastering knowledge, emphasizing technique, and gaining autonomy are used by physicians to gain control over uncertainty, we propose blame may be one technique that allows physicians to gain control over both uncertainty about outcomes and over unexpected patient outcomes associated with error (Light, 1979).

Blame serves beneficial purposes additionally by providing opportunities for learning and growth. We suggest that physicians see blame as valuable in improving practice, accepting responsibility, forgiving others and achieving control. Our observations are in accordance with more recent calls for a "fair-blame culture," in which a systems approach to error is balanced by individual responsibility (Timbs, 2007). Although our intention with this essay is to highlight the limited prospects for a blame-free culture in medicine, several implications may follow. Through discussions with those less experienced, senior physicians can normalize blame and encourage self-blame as a means to self-improvement and empathy with colleagues; at other times, they may provide critical perspective that sometimes poor outcomes occur with the best of care. Likewise, "grief" rounds may allow physicians to more directly explore emotions that are evoked by caring for seriously ill patients

(Ruopp et al., 2005). In short, blame is ingrained, accompanied by benefits, and limits a systems perspective on error. It seems unlikely that it can – or should – be eliminated from medical consciousness.

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