ONLY CONNECT **Nicholas A Christakis**

Don't just blame the system

The problem with the systems approach to error is that it suggests no one is or can be responsible

Iatrogenic deaths certainly exceed 50 000 per year in the United States, placing them among the top 10 killers. And low quality or malignant health care imposes extremely high personal and financial costs.

The dominant paradigm for understanding both the causes of, and solutions to, these problems is that of "systems" thinking. The problems of medical error and poor quality are felt to originate in breakdowns in complex healthcare systems, in suboptimal communications between providers, or in failures of equipment, processes, or institutions. The solutions are likewise typically described as requiring a systems approach, with increased computerisation, increased standardisation, or changes in reimbursement that reward high quality care.

These policy manoeuvres are no doubt important and desirable. And this systems perspective has great value and has led to important improvements in patient safety. Computerised medication order entry systems alone have saved thousands of lives.

Yet, as part of this paradigm, official policy-making bodies and experts in medical error have championed the need for a "blame free culture" in medicine. 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 to be viewed largely as systems based, as impossible to eradicate completely, and as infrequently traceable to truly negligent actions. Blame is seen as doing more harm than good, as engendering feelings of inadequacy or fear, and as ultimately pushing analysis and recognition of mistakes underground and limiting opportunities for improvement.

But the problem with this blame free, systems perspective is that it shifts attention away from the inherently moral nature of medical practice, treating it—as its advocates intend—like any other industry. If only we had the right systems and the right financial incentives, the thinking goes, then our health system would produce healthy patient widgets 100% of the time.

Moreover, the systems perspective glosses over the fact that even if we were to correct all the systems problems and implement perfect financial incentives, mistakes and poor quality would still, necessarily, occur. Indeed, even the proper practice of medicine can result in harm to patients because medical care is not, after all, a manufacturing process. It is inherently risky: the patient's body experiences the deliberate intrusion of chemicals or steel.

Finally, the systems perspective, even while extolling the ways it accounts for human fallibility, fails to account for an equally human tendency: feeling responsible.

Hence, a worrisome problem with the systems perspective is that it is conveniently self exculpatory. It lets both individual physicians and the medical profession off the hook when a patient is injured or dies as a result of a medical mistake or of poor quality care. Systems based solutions all too easily and conveniently morph into excuses and make it seem that no one has to feel responsible. Yet after more than a decade of telling doctors that medical errors principally originate in the system, most doctors I know still do feel personally responsible when bad things happen to their patients, even if, in fact, they did nothing wrong! They still take the blame. Why is this?

Because the flip side of blame is credit. Since our interventions are powerful enough to save patients, adverse outcomes must also be the result of human agency. That is, physicians take the blame, both individually and collectively, because they also want and get the credit for medical actions. They regard responsibility for both favourable and unfavourable outcomes, for both success and failures, as part of the profession. We no more want to blame computer systems or medication packaging for our mistakes than we want to give them credit for our success.

PAUL SCHNAITTACHER

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Doctors, in the end, think like patients.

What comfort or explanation is it to a person who has lost a loved one as a result of a medication error to know that better information technology might have prevented the error? What comfort is it to the patient in whom a surgical instrument is left to know that many experts believe the solution is to institute routine procedures to count instruments? What comfort is it to the patient whose pain during his terminal illness is untreated to know that, if regulations had been tinkered with, their doctor would have been more likely to care for them more humanely?

The problem with industrial solutions to the healthcare quality crisis is that they answer the patient with complaints and worries about his care by saying that no one—no person, no doctor—is or can be responsible. These solutions wrongly situate the issue in an amoral, almost mechanistic, domain.

Physicians can be held to higher account. And they want to be held to higher account. What the healthcare system needs to focus on is not only the way that information technology, systems improvements, institutional rearrangements, or novel payment mechanics can improve the "industry," but also the old-fashioned doctorly virtue of personal responsibility. The secret to the care of the patient is to care for the patient. No amount of regulation, process improvement, or reimbursement can change this fundamental fact.

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