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Responsibility and reflection: Understanding our responses to perceived errors. A response to Woodward, Lemer and Wu

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A fourth-year medical student in the USA assumed responsibility for a patient with esophageal cancer as a member of a consultation team. In her initial examination, the student noted asymmetric, non-tender lower-extremity swelling. She documented the edema in her note but did nothing additional with this information. Her team was focusing on pain, and she assumed that the primary team was handling day-to-day oncologic concerns. Five days later, with a change of members in the primary team, a new intern noted the swelling, ordered an ultrasound, and a lower-extremity deep venous thrombosis was diagnosed. A familiar series of events unfolded: the student recognized her lapse as an error; she felt deeply ashamed and guilty; she worried that her error had led to a delay in diagnosis, and that this had caused preventable harm to the patient. She reported her error and sense of shame to her attending, and asserted the desire to disclose and apologize for the mistake to the patient. The attending physician agreed that while an error had been made, there were mitigating factors. The attending shared her own experience of committing a more devastating mistake as a young trainee. The student perceived these words as comforting and supportive, but the feelings of shame persisted even after she disclosed the error to the patient. Internally, she vowed never to ignore asymmetric edema.

Were there systemic factors that contributed to this error? Absolutely. None of the many other participating physicians had read the student's documentation of the physical examination, only the assessment and plan. The likely harried initial primary intern had not noted the edema himself. A change in teams brought a change in perspective, bringing new information to bear. The student's formal education did not emphasize asymmetric swelling as a never-miss symptom. As the first author of our article in this issue of *Social Science & Medicine* "On the Prospects for a Blame-Free Medical Culture" (Collins, Block, Arnold, & Christakis, 2009), the student described above likely understood more than the average student in her position about blame and the systemic prevention of error. But this did nothing to prevent her from experiencing this mistake as deeply personal, and from accepting complete responsibility for it herself.

In highlighting the limited prospects for a blame-free culture, our goal is not to prevent progress in the error prevention movement.

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We agree with much of Woodward, Lemer and Wu's provocatively and inaccurately titled commentary "An end to the witch hunts: responding to the defenders of blame and shame" (this issue). We are for patient safety. We want fewer errors. We too believe that attention to system issues is the best way to achieve this goal. Our goal was to describe our sense of the culture of medicine, the role of blame in this culture and how it may complicate the safety movement. We hope that "a more nuanced argument" will help us see the way forward (Woodward et al., 2009).

One point of clarification: while we are palliative care physicians (RMA, SDB, NAC), the physicians interviewed were internal medicine attendings and residents involved in the care of the index dying patients. Our findings may not be generalizable: we only studied two institutions, both quaternary institutions in the United States. And our focus on patients who have died "may create within physicians a heightened sense of responsibility, and a questioning of performance" (Woodward et al., 2009). Further studies would be needed to clarify this.

The commentary by Woodward et al. focuses on blaming others, but we do not endorse this. Indeed, our essay highlights the propensity towards self-blame and argues that blaming colleagues is uncommon (Christensen, Levinson, & Dunn, 1992; Collins et al., 2009; Mizrahi, 1984). It may be true that "the overwhelming majority of adverse events are not the fault of any one person, but rather the result of system problems" (Woodward et al., 2009), but we argue that errors are experienced in the opposite proportions. Self-blame predominates, allowing physicians to exercise autonomy and accept responsibility for both the successes and failures of their practice (Leape & Berwick, 2005); this inhibits a systemic view of error.

The commentary's argument also rests on parsing the vocabulary of blame, shame and guilt. We agree that this debate suffers from "fuzzy" or absent definitions (Kaldjian, Jones, & Rosenthal, 2006; Woodward et al., 2009). Unfortunately, even Woodward et al. unreferenced construction of shame is not an accepted definition, and the Oxford English Dictionary defines shame as closer to that given in the commentary for guilt, as "the painful emotion arising from the consciousness of something dishonouring." Fear, shame, guilt, remorse, blame. While we may disagree on definitions, we differ less in the content of our arguments.

We strongly agree with Woodward et al. on the importance of individual responsibility. We hope this can be harnessed for change among individuals, and for teams. We worry that eliminating or reducing a central construct such as blame may be difficult and lead to a diminished sense of responsibility. Self-criticism is a large part of the ethos of medicine; appropriate self-criticism helps us become better physicians. But as Woodward et al. suggest, and as was experienced by the student/first author in the example cited above, our goal is to encourage reflection on how we deal with emotions of guilt and self-blame. Rather than suppress and push these natural and human feelings underground, we argue and hope that we can and should share these emotions, acknowledge guilt and shame, receive empathy, apologize, and learn.

Remorse in response to error is a common response. Whether mistakes elicit remorse, shame or guilt, we believe that these pervasive emotions spur growth. As we describe, self-blame stimulates self-reflection, learning, empathy with fellow physicians, and functions as a way to achieve control over clinical outcomes. In our interviews, we found very little description of the witch hunt and firing described by Woodward et al. (2009). Indeed, we highlight how reluctant physicians are to blame their colleagues. For better or worse, the witch hunt is not turned outward, but lies within. Rather than dismiss this, we need to understand it to move forward in our united desire to reduce error.

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