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Workplace Blame and Related Concepts
An Analysis of Three Case Studies

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Blame has been thought to affect quality by decreasing error reporting. Very little is known about the incidence, characteristics, or consequences of the distress caused by being blamed. Blame-related distress (B-RD) may be related to moral distress, but may also be a factor in burnout, compassion fatigue, lateral violence, and second-victim syndrome. The purpose of this article is to explore these related concepts through a literature review applied to three index critical care clinician cases. CHEST 2015; 148(2):543-549

ABBREVIATIONS: B-RD = blame-related distress

Workplace blame is believed to worsen care delivery and patient safety, because clinician behavior, such as fear of blame[1] or perceived dishonor,[2] can lead to decreased error reporting.[3] However, the incidence, characteristics, or consequences of the distress caused by blame have not been described in the literature to date. It is possible that blame-related distress (B-RD) may be triggered by, and contribute to, other environmental or individual patient safety determinants such as moral distress, burnout, compassion fatigue, lateral violence, and second-victim syndrome. The purpose of this article was to explore these related concepts through a literature review applied to case studies. The index case analyses served as the impetus to explore the concept of B-RD in preparation for a research program (reported separately).

Composite Cases

According to a study by the Office of the Inspector General, US Department of Health and Human Services, approximately one in seven hospitalized patients experiences a serious adverse event.[4] Another one in seven is affected by a less serious adverse event. Although this statistic is shocking, the impact blame associated with the healthcare provider in this context appears to have been overlooked. The following anonymized, real-scenario-based cases are presented to help gain a better understanding of how blame impacts clinicians in the workplace.

Case 1

Consider a physician who has practiced for many years without significant negative events. One day a critically ill patient dies following an elective procedure carried out

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by the physician. ICU staff nurses associate the procedure with the patient's death; however, no debriefing occurs. The physician looks back and feels bad for the patient but cannot find anything that he had done differently in previous cases that could have caused the outcome. The nursing staff's distress escalates, and hospital management blames the physician for the death without due process. He sees this as unjustified because he did nothing intentionally to cause the death; an autopsy confirms an unexpected complication that explains the patient's demise. He feels shunned by those once considered colleagues and spends years addressing complaints sent to various governing and academic bodies by the hospital's administration. The recruit hired to replace him publicly describes having to replace him because of a death he caused. He takes on shift work at a geographic location remote from his home and children. In this less stressful environment, he is able to deemphasize the questioning of his abilities and fear of shaming by others. He slowly rebuilds his confidence. Years later he can remember the blame as if it had occurred moments ago, every detail emblazoned in his memory. The distress subsides but never truly goes away.

Case 2

As is customary in hospitals in which physicians are not staff members, a nurse leader writes policies at their request. One policy allows a medication known to cause respiratory depression to be administered to patients who are not intubated. The nurse's literature review reveals evidence that others have successfully implemented a similar policy for the off-label use of this medication. He contacts the organizations that have published this evidence and uses their policy as a basis for the practice change. He implements the practice change with the precautions that the receiving patient must have a dedicated nurse and that audible alarms be monitored at all times while the patient is in the ED or ICU. He was proud of the evidence-based analysis and of the measures put into place to ensure patient safety. A patient receiving this medication receives a free-flow of the medication caused by a pump malfunction and has a respiratory arrest. The supervisor subsequently blames the nurse who wrote the policy for the negative patient outcome. The nurse loses faith in the organization because the policy had been reviewed at many committee meetings and approved by physicians and the organizational leadership. He questions himself and his leadership abilities and ruminates about the experience. He is despondent and suffers sleeplessness and recurrent averse memories of the moment when his supervisor blamed him for the outcome. He leaves the organization but even years later avoids policy-writing responsibilities. He has difficulty driving past the hospital at which this event occurred. Others misinterpret his aversion to situations at work that could have a similar outcome as apathy. It takes years and a change in position for his confidence and pride in his work to return in his chosen profession.

Case 3

A new nurse experiences her first patient with a cardiac arrest. She is the nurse administering medication during the resuscitation event. The patient expires. She is called into the supervisor's office the next day and told that she administered an undiluted vasopressor (which should have been admixed into a piggyback solution and administered slowly on a pump) and that this was the likely cause of the patient's death. She cannot live with the fact that she could have "killed" another human. She goes into the medication room and self-administers a lethal injection of a toxic substance. Her peers find her dead.

Moral Distress

Of all of the concepts related to blame, most is known about moral distress. Ethical beliefs emerge from professional codes of ethics, political views, family values, religion, and work and life experience.[5] Because of differences among each individual's personal history, any given situation may have more than one right course of action. Moral distress occurs when the individual's perception of personal and professional values or ethical obligations is violated, resulting in psychologic distress.[6] If those involved in provision of care or decision-making feel that their personal values, principles, or beliefs have been compromised, moral distress may result.[7] Moral distress may lead to feelings of sadness and powerlessness, avoidance behaviors, anger, and frustration that may adversely affect patient care.[6,8] This distress may continue long after the event has occurred.[8-11] The lingering distress following the initial moral distress has been termed moral residue.[7,8]

Organizational culture also influences moral distress. Organizational processes, structures, and policies may lead to moral distress when the right action is clear to the individual, but he or she is prevented from taking this action because of these organizational issues,[12] as was the case in the debriefing requested in case 1. Societal or political issues within or beyond the organization may also frame a culture that prevents people from