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Effects of Shame and Guilt on Error Reporting Among Obstetric Clinicians

Mara Lynne Zabari and Nancy L. Southern

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Correspondence
Mara Lynne Zabari, PhD, Conscious Healthcare Designs, P.O. Box 33937, Seattle, WA 98133.
mara@conscious.healthcare

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ABSTRACT

Objective: To understand how the experiences of shame and guilt, coupled with organizational factors, affect error reporting by obstetric clinicians.

Design: Descriptive cross-sectional.

Setting and Participants: A sample of 84 obstetric clinicians from three maternity units in Washington State.

Methods: In this quantitative inquiry, a variant of the Test of Self-Conscious Affect was used to measure proneness to guilt and shame. In addition, we developed questions to assess attitudes regarding concerns about damaging one's reputation if an error was reported and the choice to keep an error to oneself. Both assessments were analyzed separately and then correlated to identify relationships between constructs. Interviews were used to identify organizational factors that affect error reporting.

Results: As a group, mean scores indicated that obstetric clinicians would not choose to keep errors to themselves. However, bivariate correlations showed that proneness to shame was positively correlated to concerns about one's reputation if an error was reported, and proneness to guilt was negatively correlated with keeping errors to oneself. Interview data analysis showed that *Past Experience with Responses to Errors*, *Management and Leadership Styles*, *Professional Hierarchy*, and *Relationships With Colleagues* were influential factors in error reporting.

Conclusion: Although obstetric clinicians want to report errors, their decisions to report are influenced by their proneness to guilt and shame and perceptions of the degree to which organizational factors facilitate or create barriers to restore their self-images. Findings underscore the influence of the organizational context on clinicians' decisions to report errors.

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Mara Lynne Zabari, MPA-HA, PhD, is a consultant for Conscious Healthcare Designs, Seattle, WA.

Nancy L. Southern, EdD, is an adjunct faculty member for Saybrook University, Oakland, CA and a consultant for Nancy Southern & Associates, Placitas, NM.

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Recent estimates suggest that medical errors are the third most common cause of death in the United States (Makary & Daniel, 2016), and many medical errors are preventable (James, 2013; Kohn, Corrigan, & Donaldson, 1999). Of even more concern, the prevalence of errors is underestimated, and a considerable number of these errors remain unreported (Levinson, 2012). This situation is caused, in part, by issues that stem from the professional culture of perfectionism in health care in which vulnerability is perceived as a sign of weakness, and individuals are shamed and blamed for mistakes and poor outcomes (Dekker, 2013). For obstetric clinicians, this professional culture prevents the psychological safety needed to raise concerns (Lyndon et al., 2012; Maxfield, Lyndon, Powell Kennedy, O'Keeffe, & Zlatnik, 2013) and report their errors (Miller, 2003).

Although relationships between the professional culture and safety behaviors among obstetric clinicians have been established (Lyndon et al., 2015), little is known about the specific features of the culture that cause obstetric clinicians to decide to report or conceal their errors. To learn from errors and improve the quality of maternity care, obstetric leaders and clinicians should understand these features so they can take action to create a supportive culture for error reporting.

Background

For nearly two decades, major efforts to institute safety cultures have been underway to improve patient outcomes by fostering safe collaborative learning environments in which the reporting of safety concerns and errors is promoted (National Patient Safety Foundation, 2015). Although progress has been made, including the use of team training and structured handoff communications (National Patient Safety Foundation, 2015) for transparent error reporting, the overall objective of the safety culture movement has not

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In environments perceived as risky, guilt induces approach and repair behaviors, whereas shame induces withdrawal and concealment behaviors.

been achieved (Agency for Healthcare Research and Quality, 2014; Perez et al., 2014; The Joint Commission, 2017). For obstetric clinicians, error reporting can be even more challenging than for practitioners of other specialties because childbirth is perceived as a life event rather than a medical event, and families expect perfect outcomes (Carranza et al., 2014).

The failure to make significant progress in error reporting is likely because of the limitations of the lens through which safety culture is typically conceptualized and studied, which does not include important social, cultural, and political factors (Waring, Allen, Braithwaite, & Sandall, 2015). To widen this lens, in our research we drew from advances made in the social sciences on responses to mishaps to better understand obstetric clinicians' error-reporting behaviors. Specifically, research findings indicated that responses to transgressions are largely determined by individuals' experiences of guilt and shame within their social contexts (Tangney, Youman, & Stuewig, 2009).

Guilt and Shame

Although guilt and shame are often generated by similar types of events, there are important distinctions between the two constructs that can help to understand the underreporting of medical errors. Feelings of shame are associated with perceptions of failure of self, whereas feelings of guilt are associated with perceptions of failure of behavior (H. B. Lewis, 1971). An example of this distinction is an obstetric nurse who makes a medication error and feels remorse after seeing how her actions negatively affected her patient (guilt), or she feels ashamed of herself for making the error because she attributes it to a fundamental flaw in her nature (shame).

The different responses elicited by the experiences of guilt and shame are dependent on the degree of control people perceive they have in given situations. In self-conscious emotions theory, it is suggested that when an obstetric nurse experiences guilt, feelings of regret typically motivate reparative action (i.e., reporting an error) because the nurse perceives that the source of the transgression is her own behavior, over which she has some control. On the other hand, a nurse who experiences shame may withdraw from the situation (i.e., conceal the error) because she perceives that her innate character is the source of the transgression, over which she has little control (Tangney & Dearing, 2002). The withdrawal tendency is fostered when people who feel shame perceive that their environments are too risky to restore their self-images (de Hooge, Zeelenberg, & Breugelmans, 2011). In this example, when the obstetric nurse attributes the error to her own behavior (guilt), even though she may have to face difficult consequences, she will be more inclined to come forward and report the error because she believes that she can improve the situation by making amends. In contrast, when the nurse attributes the error to a deficit in herself (shame) and if she perceives her environment to be punitive, she will be more inclined to conceal the error because she is afraid that if she comes forward, her flaws will be exposed and her reputation will be ruined. Although this example uses a nurse to illustrate the effects of guilt and shame on error-reporting behaviors, these responses are applicable to all obstetric care providers.

The purpose of our study was to bring a systems perspective to the individual and organizational factors that facilitate or create barriers to error reporting among obstetric clinicians by answering the following research questions:

1. What are the degrees of proneness to guilt and shame in obstetric clinicians who practice in hospitals?
2. What are the relationships between proneness to guilt and shame among obstetric clinicians and their attitudes with regard to error reporting?
3. How do organizational factors affect error reporting among obstetric clinicians?

Methods

Design

A descriptive, cross-sectional design was used to evaluate the degrees of proneness to guilt and shame among obstetric clinicians and the relationships among these variables and the clinicians' attitudes about error reporting. Additionally, organizational factors that facilitate or create barriers to error reporting were assessed. The study protocol was approved by three institutional review boards (one researcher's institutional

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