



## 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,

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