Taking the blame: appropriate responses to medical error

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ABSTRACT

Medical errors are all too common. Ever since a report issued by the Institute of Medicine raised awareness of this unfortunate reality, an emerging theme has gained prominence in the literature on medical error. Fears of blame and punishment, it is often claimed, allow errors to remain undisclosed. Accordingly, modern healthcare must shift away from blame towards a culture of safety in order to effectively reduce the occurrence of error. Against this shift, I argue that it would serve the medical community well to retain notions of individual responsibility and blame in healthcare settings. In particular, expressions of moral emotions—such as guilt, regret and remorse—appear to play an important role in the process of disclosing harmful errors to patients and families. While such self-blaming responses can have negative psychological effects on the individual practitioner, those who take the blame are in the best position to offer apologies and show that mistakes are being taken seriously, thereby allowing harmed patients and families to move forward in the wake of medical error.

INTRODUCTION

Like our errors in everyday life, errors in medical contexts are extremely common. As reported by the Institute of Medicine, an estimated 44 000–98 000 deaths per year in the USA alone are attributed to medical error.[1] Surprisingly, the body of bioethics literature addressing moral responsibility for medical error is quite sparse. Of the attention that has been given, much of it has focused on the importance of informing patients and what exactly should be said when something goes wrong.[2–5] In a recent account, Berlinger and Wu suggest that medical education should include learning how to disclose errors, apologise, meet injured patients' needs, confront the 'emotional dimensions' and take responsibility for one's mistakes.[6] Still, the ideas of confronting emotions and taking responsibility are far from clear, particularly when it is said that 'responsibility should not be confused with blame'.[6] In fact, this work is one among a larger shift in recent times away from notions of blame in healthcare.

In a follow-up to the Hastings Center's report, 'Promoting Patient Safety',[7] Meaney argues that we must transition from a 'culture of blame' to a 'culture of safety'.[8] Yet, ensuring patient safety should be an obvious and ongoing objective. Furthermore, the shift away from notions of blame stands to deprive us of a crucial resource for promoting systematic improvements, on both a personal and an institutional level. As I argue, it would serve the medical community well to retain notions of individual responsibility and blame in healthcare settings. In particular, expressions of moral emotions—namely guilt, regret and remorse—appear to play an important role in the process of disclosing harmful errors to patients and families. While these sorts of self-blaming responses can have negative psychological effects on the individual practitioner, those who take the blame are in the best position to offer apologies and show that mistakes are being taken seriously.

My argument for the importance of blame in disclosing medical error will proceed as follows. First, I adopt a straightforward understanding of medical error and some examples to set the stage. I then critique the arguments for prioritising safety rather than blame as the most appropriate response to errors. While I do not intend to dismiss the need to work towards increased safety, my purpose will be to re-establish the significance of blame in healthcare settings. Finally, I argue that taking the blame provides an effective means of allowing harmed patients and families to move forward in the wake of medical error.

MEDICAL ERROR

Our understanding of medical errors need not be complex nor controversial; however, the analysis to follow will be made clearer by establishing several basic points. First, following the Institute of Medicine, *error* can be known as the 'failure of a planned action to be completed as intended…or the use of a wrong plan to achieve an aim'.[1] Second, errors in healthcare settings often lead to *adverse events*, namely, harms 'caused by medical management rather than the underlying condition of the patient'.[1] Third and finally, unlike the widely cited report, I will not assume that all adverse events occurring as a result of medical error are preventable. Indeed, some cases show that a patient's injury or death may be an extremely adverse event brought about by medical error, and one that could not have been prevented given the circumstances.[9]

Consider Nurse Martha Warren, an oncology nurse at an understaffed hospital.[10] On a particularly unfortunate shift, Nurse Warren finds herself responsible for tending to five patients, two of which suddenly need immediate life-saving attention. Naturally, she cannot be in two places at the same time, and she chooses to tend to patient 1 while patient 2 has a cardiac arrest and dies. While patient 2's death is an adverse event to the extent that it was caused by medical management, it is not obvious that Nurse Warren should apologise for her actions. After all, it was simply not possible for her to fulfil every competing demand that had been

placed on her. Accordingly, she may be tempted to blame the system, say, for continually allowing critical understaffing. But how exactly would blaming the system help the grieving family? Given that the death of patient 2 occurred on her watch, it seems she owes a personal explanation. I will return to this example, below, in arguing that the explanation would be best received where Nurse Warren takes the blame.

For the moment, consider a second example. Doctor Jean Robert administers insulin to her patient with diabetes after failing to see that an attending nurse has already administered the appropriate dosage.[11] While overdosing can have lasting and even fatal effects, Doctor Robert's patient experiences moderate but temporary discomfort. Unlike the previous case, here it is obvious that the adverse event could have been prevented, say, by Doctor Robert double-checking with the attending nurse. Again, there may be a temptation to pass-off blame onto larger, systemic issues at hand. No doubt, the prospect of letting oneself *off the hook* may seem even more tempting—and quite feasible—considering the doctor's position of power. Perhaps the nurse could have noted more clearly that the dosage had been administered. Yet, deflecting blame in this way appears somehow wrong, particularly when one's ability to do so is directly correlated with an imbalance in power relations. Intuitively, some circumstances more than others allow one to appropriately deflect blame away from oneself. Yet, recent literature suggests that we should shift altogether away from a culture of blame. These suggestions have created a peculiar dichotomy concerning our responses to medical errors.

BLAME OR SAFETY?

As the examples above suggest, we might think blame is entirely fitting, at least in cases where the practitioner could have reasonably prevented the adverse event. On the other hand, blame itself is often seen as contributing to the ongoing harms. A common theme to the arguments supporting the shift away from blame is the idea that it may actually hinder our attempts at systemic change. It is claimed that medical professionals fear being blamed due to the risk of malpractice lawsuits and the stigma attached to having one's expertise called into question. Clinical nurse specialist Lisa Day, for example, says 'if providers fear a punitive response from management they will be more likely to hide their errors…*blame-free error* and the elimination of shame by shifting inquiry to the system is an important step toward a safer hospital environment'.[12]

Because blame may allow errors to remain hidden, many authors support more comprehensive reforms, such as non-punitive reporting and collective accountability.[6 8 12–17] However, it is not clear that removing or avoiding blame in medical settings is possible, nor is it necessary for improvements in safety or patient-practitioner relations. Furthermore, removing notions of blame threatens to drastically reduce the efficacy of apologies and forgiveness in cases where such exchanges can help to move forward. In other words, blame-free errors in healthcare are not possible or necessary, nor are they desirable.

Blame-free errors are not possible

The blame-free arguments commonly fail to account for the fact that blame directed at medical practitioners can have various sources. Blame might emerge from the harmed patient or family, from fellow practitioners or the general community, or simply from oneself. The thought of being blamed by others may well reinforce the fear of receiving punishment. However, self-blame should often be inescapable for the practitioner who truly values the well-being of her patients. By self-blame I have in mind the process by which one responds negatively with some sort of reproach toward her decisions or actions. Self-directed emotional responses such as guilt, regret and remorse fit this profile by definition. And while these affective experiences are often perceived negatively, there is much more to the 'negative' moral emotions than their affectivity.

In recent theories of emotion, it is said that responses akin to guilt, regret and remorse (among others) are made up of an affective quality (or *feeling*), an evaluative appraisal of the object and a tendency to act in some distinct manner.[18 19] In experiencing guilt, one feels bad about oneself, typically for having violated a justified norm.[20] A guilty person evaluates himself as morally spoiled and is often motivated to make amends, in an effort to 'undo the deed'.[21] Regret may evaluate general states of affairs—say, unavoidable tragedies—or one's own actions. As Bernard Williams established, a species of emotion famously dubbed 'agent-regret' captures the idea that one can regret his actions even where the circumstances were beyond control.[22] Importantly, regret is often a feeling of loss,[23] one that motivates the agent to change his decision-making policies.[24] Finally, remorse is likewise a characteristic feeling of loss or failure that evaluates one's actions negatively. But unlike regret, remorse can be seen as targeting actions that are entirely *owned* by the remorseful agent.[25]

Despite their differences, moral emotions akin to guilt, regret or remorse often share as characteristic action tendencies a motivation to improve the future, either in one's actions or generally in how events transpire. Such negative emotions are persuasively invoked by responsibility theorists as constituting forms of self-blame.[26 27] Granted, cases where medical error cannot be prevented are such that the practitioner *should not* be blamed, by others or by oneself. As a normative matter, these agents are simply *not to blame*. Consider, again, the oncology nurse who did all she could possibly do. Because the patient's death is properly attributable to staffing shortages, 'responsible blamers' will be more inclined to point fingers at hospital management, rather than at the practitioner who finds herself facing a tragic dilemma.[28] To be sure, we should expect hospital management to be prepared to offer apologies, commit to improvements and so on.

Still, the point to be made here is descriptive: for the practitioner whose action brought harm to her patient, it is hard to imagine her being without some response akin to guilt, regret or remorse. Indeed, self-blame will often be largely automatic. In a study on blame in palliative care, Collins *et al* conclude that physician 'self-blame is ingrained…as a response to perceived errors'.[29] Thus, while they may not be fitting targets of blame, practitioners are disposed to blame themselves nonetheless for harms even beyond their control.[30 31] Notice, also, that in practice we tend to blame others less when we see that they are clearly blaming themselves.[32] By contrast, where one fails to blame herself, others are more likely blame, that is, both for the perceived error and for not responding appropriately. In this way, it seems that where there are errors we should expect to see blame.

Blame-free errors are not necessary

Contrary to the fears of punishment cited by those who oppose blame in healthcare, self-blame expressed through an apology may well *decrease* the risk of malpractice lawsuits. According to one study, almost half of malpractice claimants say they would not have filed the suit if they had received an apology.[33] As it turns out, most patients harmed as a result of an error 'wanted

to prevent the same thing from happening to someone else, to receive an explanation for what had happened, or for the doctors to realise what they had done'.[34] Should practitioners readily blame themselves, they would be in a better position to convey that the error is being taken seriously and that they are committed to improving their practices. Retaining notions of blame—namely, self-blame—can, in this way, help to circumvent or at least decrease punitive measures from others. Of course, it cannot be denied that self-blame is itself a sort of punishment, one that may have lasting psychological effects, such as practitioner dissatisfaction and burnout, and further downstream consequences for healthcare institutions. I will return to these important considerations before concluding.

It might be thought that blame will only upset the erring practitioner and thereby will hinder any impetus to improve.[35] Removing blame, then, would represent a vital step towards safer healthcare. However, doing away with blame is not necessary for improvements. Surely, efforts can be made to increase patient safety without moving away from the so-called 'culture of blame' that is said to pervade healthcare. In fact, some have found that practitioners who accept responsibility are *more* likely to improve their practices than those who do not.[36] As suggested above, self-blaming responses motivate one to repair the wrongs and to change the future for the better.[21 24 25] Those who engage in self-directed blame are inclined to learn from mistakes, and by conveying such motivations, the reasons to be blamed by others can be alleviated. That is, victims of harmful errors can be assured that practitioners will improve in ways that help to protect future patients from similar events. Thus, removing blame is not only unnecessary, it may well work against the goals of re-establishing patient-practitioner relations and of improving clinical practices. Meanwhile, efforts to increase patient safety can be made independently from any shift away from blame. Indeed, continual improvements in safety should not depend on whether or not we do away with any sort of blame.

Blame-free errors are not desirable

Moral theorists have often thought that in order to be forgiven, one must show an understanding of the harm, apologise for and repudiate the action in question, make amends for the damages and so on.[37–39] The very idea of apologising seems to entail an acknowledgment that one was at fault or could have helped to prevent harm.[24] Without a genuine sense of guilt, regret, remorse or some related response, it may appear that one does not fully understand the harm she caused. Without some notion of blame, then, the process of offering an apology is without the meaning and value it possesses in ordinary interpersonal exchanges. And if apologies are indeed a key component of forgiveness, doing away with blame is likewise to remove the possibility of forgiveness. For these reasons, rendering errors blameless looks to be far from desirable.

Berlinger and Wu maintain that the goal after medical error has occurred is to enable patients' forgiveness. With this in mind, they recommend that physicians take 'prospective' responsibility—engage in forward-looking discussions, improvements and disclosure—but not blame.[6] Still, when seeking to repair damaged patient-practitioner relations, we must ask whether or not we truly want practitioners to be entirely blame-free, no matter the error in question. For those like Doctor Robert—those who could have and clearly should have acted differently—it is at best unclear why or how one would be held responsible but blameless. Here, we begin to see the importance of self-blame as a mechanism that stands to achieve distinct consequential goods. For imagine Doctor Robert's patient, who could have suffered

unspeakable harm, receiving an apology from an utterly inured practitioner. No doubt, being morally responsible but without some response akin to regret or remorse would render apologies less effective and forgiveness less appropriate.

If our goals in the wake of medical error include such crucial measures as assuring increased safety and enabling patient forgiveness, it seems we must utilise all resources at our disposal. Systemic efforts, such as more efficient reporting and disclosure of errors are, of course, one obvious route. Allowing for practitioner self-blame, perhaps even encouraging it, is yet another. As Berlinger and Wu aptly state, the 'physician-patient relationship exists between individuals, not between a person and a *system*'.[6] The removal or avoidance of individualised blame merely decreases the means by which we can help patients and families to move forward.

TAKING THE BLAME

While I have argued for the importance of self-blame, in some cases responses like guilt and regret appear to be somewhat irrational, namely where a practitioner could not have prevented the adverse event. Nonetheless, those who take the blame are in the best position to disclose errors, apologise and to demonstrate a commitment to improvement for themselves or on behalf of their institution. In this final section, I explain what it means to take the blame, why it should often be encouraged, and how to account for the negative psychological effects for individual practitioners.

Consider that there are cases where one is not strictly liable in the sense of owing reparations, but at the same time, a harm has been inflicted and it is somehow connected to the agent.[25] Bernard Williams's widely discussed response known as *agent-regret*, surveyed above, illustrates the reaction we might expect. In Williams's famous example of moral luck, a lorry driver 'through no fault of his, runs over a child'.[22] Of course, the driver is not blameworthy for the unfortunate state of affairs; yet he feels appropriately bad in a way that differs from the bad feelings of any bystanders. Importantly, with his unique connection to the events—being causally but not morally responsible—the driver is in a privileged position to help the existing victims or to inflict further harm. That is, he can express his genuine sense of regret and allow, say, the child's parents to find solace and begin moving forward. Alternatively, he might convey—truly yet callously—that he was not at fault.

Referring to these sorts of cases as 'ambiguous agency', in a recent work, Mason makes clear that it is often *up to us* to indicate how a morally significant loss should be taken.[25] Many of our relationships, Mason claims, entail duties that require an 'attitudinal back-up'. We must be invested in our duties to others, in the sense that fulfilling *or failing to fulfil* them will be accompanied by distinct reactions and feelings. In particular, apologies involving expressions of remorse allow us to show others that we are willing to 'own' certain actions. However, in doing so, we not only take *responsibility*, as Mason holds; for indeed responsibility may belong to us in part as things stand. By taking ownership of harms to others and for damages entirely beyond our control, we show a willingness to take the blame.

But why exactly would we do this? As we can imagine, where we are not fully responsible for harms that befall those within our care, an expression of remorse (or guilt and related responses) might simply open us up to external blame and further punitive measures. On Mason's account, seeing an action as our own allows us to 'secure the respect and trust of others'.[25] We should be willing to take the blame by expressing negative moral

emotions and owning certain actions because of the goods to be achieved for oneself and the institution one represents, and for the substantial benefits imparted on those to whom we have a duty.

In medical settings, patients and families can be reassured that harms are being taken seriously, that practitioners are more concerned with the damages, and how to prevent the recurrence of similar tragedies, than with their own innocence. As Mason notes, we can limit what will 'count as an excuse', even where excuses are clearly available.[25] Doing so stands to provide immediate consolation as well as hope for an improved future. Additionally, if taking the blame succeeds in providing some degree of consolation and hope for improvements in the delivery of healthcare, practitioners stand to effectively re-establish the respect and trust coveted within the patient-practitioner relationship. Granted, Mason has in mind the ambiguous harms occurring in *personal* relationships, cases which are unlike the lorry driver and unlike situations involving medical errors. Nonetheless, the mechanism by which we might apologise for errors—including those beyond our control—likewise encompasses our investments in *professional* duties. Several considerations support this expansion.

First, it is clear that some professional domains entail duties that bear great moral significance. As Williams points out, 'lawyers and doctors have elaborate codes of professional ethics…because their clients need to be protected, and be seen to be protected, in what are particularly sensitive areas of their interests'.[31] Indeed, the duties held while occupying certain offices are such that their failure to be fulfilled may result in catastrophic harm to those who depend on their fulfilment. Given this sort of dependence, there will be situations in which one's failure to deliver cannot be let *off the hook*. In short, the harms demand an explanation and sincere offering of reassurance. Notably, this demand is plausibly made in cases of deliberate or inadvertent harms, and it is often most effectively met by an expression of some negative emotional response.[i]

Furthermore, professional actions involve ambiguous agency, perhaps even more frequently and more severely than in personal domains. With this recognition, the account established here can be seen as yielding practical recommendations concerning healthcare professionals' conduct. For example, practitioners may often have a sense that they alone are not entirely responsible for certain harms that befall patients. In the case of Nurse Warren, as I claimed above, it seems reasonable to suppose she owes to the family of patient 2 at least an explanation of what happened. She can acknowledge her role in the adverse event while making clear that it was the result of tragic circumstances. That being said, her explanation of the tragedy to those most profoundly affected by it should be accompanied by a negative affective experience, such as guilt, regret or remorse. With such a heartfelt explanation, the door is then open for the family to find solace and offer their understanding, as all who are affected by the tragedy can work to support one another and see that systematic improvements are carried out.

Of course, it may be that those who could have done no better in playing their part within a tragic causal chain are entirely without some negative response like guilt or regret. Very often we see practitioners who grow 'cold' to the harms and losses that occur on their watch.[40] To be sure, the notion of 'compassion fatigue' has received considerable attention in recent literature, and understandably so, as the psychological effects on healthcare professionals are significant causes for alarm. Compassion fatigue is typically seen as a form of traumatic stress, where caregivers have given too much.[41] The excessive degree or duration of their caring has, in a very real way, exhausted their ability to provide additional care. Certainly, it is of the utmost importance that we address these unfortunate realities with policies aimed at promoting practitioners' psychological health, at preventing burnout and staffing shortages, which of course have negative effects on the overall quality of patient care. Still, the claim to be made here is that where practitioners are entirely unaffected by morally significant losses, they are no longer in a position to effectively apologise to those who care for the victims. Without some degree of self-blame, however irrational it may be, practitioners are less able to show that harms are being taken seriously, and thereby less able to allow patients and families to forgive and move forward than those who take the blame.

CONCLUSION

Medical errors are unfortunately common and, no doubt, even their occasional occurrence would call for improvements in terms of patient safety. It is now widely agreed on that disclosure and often apologies are owed to patients and families who suffer as a result of errors. At the same time, some maintain that we must move away from the current culture of blame that pervades healthcare. As I have argued, the shift away from notions of blame should be resisted. Rather than fearing blame as a punitive response from others or as a potential liability, practitioners can invest in their professional duties and display a genuine sense of ownership, even for the most unfortunate of circumstances. Those who take the blame in this way are in the best position to apologise and to assure that their practices, as well as the institutions they represent, are committed to improvement.

[i]Here, I have in mind 'dirty hands' dilemmas in politics or war. Consider, also, the tragedies all too familiar recently in the USA, namely mass shootings. While the failed duty to protect innocence lives may be more or less attributable to current politicians, being truly invested in the duties of some offices surely entails taking responsibility and even blame for the harms. The respect and trust of others—of victims' families and of the nation at large—are more effectively secured by one who expresses an 'attitudinal back-up' (recall President Obama's tears in his statement following the 2012 Sandy Hook Elementary School shooting).

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