EDITORIAL

Our surgical culture of blame: A time for change

Jamie Dickey, PhD[a]
Ralph J. Damiano, Jr, MD[b]
Ross Ungerleider, MD[a]

> Here men are demoralized in the shortest possible time on the largest possible scale, at the cheapest possible price.
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> —*Soren Kierkegaard, writing about the press in the 19th century*

All of us are familiar with the recent events at Duke University Hospital, in which incompatible heart and lungs were transplanted into Jessica Santillán, leading to a second transplant and her eventual death. This was a tragedy not only for this teenage girl and her parents, family, and friends, but also for the dedicated health care professionals involved in her care. We were all touched by the pictures of Jessica before and after her surgery. But just as poignant was the televised statement by her surgeon, who accepted full responsibility for the error that led to her death. All of this was brought to us by the continuous, unrelenting media coverage. The Santillán family's suffering was palpable and understandable. The loss of a child is every parent's worst nightmare. This was accompanied by a predictable frenzy in the news media, as they tried to decipher and assign blame. Although tragic, there is much to be learned about our health care system and our specialty from this incident. It is both a clear example of the shortcomings of our surgical culture and a clarion call for change.

Throughout the history of our specialty, we have accepted the premise that the surgeon is the "captain of the ship" and must accept total responsibility for everything that occurs to a patient under his or her care. Although this is an understandable guiding principle reflecting the awesome responsibility entrusted to us by our patients, it has led to some untoward consequences, which require us to reexamine this important credo to reflect the realities of 21st century medicine. Over the past several decades, our profession has seen startling advances in technology, an ever-increasing sophistication of medical therapies, and an expanding team approach to most diseases. Our traditional egocentric philosophy of care oversimplifies the complex nature of modern health care, and if not altered, it will become an impediment to efforts at improving health care. The hierarchic structure that we have created, in which the surgeon accepts full responsibility for everyone's actions, has led us to develop a culture of blame. This culture of blame approaches every error in health care as the fault of an individual, rather than a shortcoming of the system. This was painfully evident after the tragic incident at Duke University Hospital, which also illustrated how our culture of blame feeds into the news media's and the public's worst fears and unrealistic expectations regarding our health care system.

Various beliefs have led to the adoption of this culture. The consequences of surgeon error are so high that most surgeons do not allow themselves the same latitudes for error as found in other professions. This elevation of our status to something more than human creates a trap for the surgeon, other health care professionals, and the patient. We have been trained in the captain-of-the-ship model of responsibility and as such frequently lack the information and input that comes from collaborative teamwork. Typically, surgeons see themselves as overseers of vast amounts of knowledge that is unfamiliar and indecipherable to their patients and possibly even to other team members. Surgeons position themselves as

From the Division of Cardiothoracic Surgery, Oregon Health and Sciences University, Portland, Ore,[a] and the Division of Cardiothoracic Surgery, Barnes-Jewish Hospital, St Louis, Mo.[b]

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Address for reprints: Jamie Dickey, PhD, Oregon Health and Sciences University, 3181 SW Sam Jackson Park Rd, Mail Code DCRCP, Portland, OR 97239.

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the keepers of the truth, as opposed to professional individuals with pieces of the truth who are also interested in discovering the pieces of truth held by their patients and other health care professionals. This creates the perfect set-up for blame.

Accepting the belief that errors are not acceptable creates a dynamic in which one could become less than honest about admitting error. Creating an expectation of perfection will lead to failure because no health care program can always achieve that goal. Creating a realistic expectation that allows for the occasional error is deemed unacceptable and careless by those who critique health care. As surgeons, we get caught up with the righteousness of the latter philosophy and believe we should achieve perfection—anything else is failure. Unfortunately, only those errors that can be acknowledged can be fixed. The inability, at times, to see the value in collaboration, to admit error, and to accept our humanness creates a formula for disaster for the patient, the surgeon, other health care professionals, and the larger health care system.

A function of our culture of blame has been its attempt to find simple solutions to complex problems. This is seductive to both physicians and hospital administrators because it is easier to try to isolate one component of a problem, the individual who is incompetent, and get rid of that person. Additionally, if the at-fault individual or institution can be isolated, sanctioned, or dismissed, then the victim can be vindicated.

But does assigning blame to an individual make the system safer for others who follow?

The argument is not about whether individuals who are the victims of medical error deserve to be compensated for their suffering; rather, it is about how the present culture, with its process of isolating and blaming the guilty party, perpetuates the myth that complex problems can be simplified and solved through merely figuring out the one who is to blame. What is the best approach to create system reform and error solution? What shift must occur in medical cultures so that they become cultures committed to solutions rather than blame? The social sciences tell us that it is appropriate to feel remorse and sadness when there is error. These emotions help motivate individuals and systems to explore the reasons for the error and create protocols and solutions for addressing the error. Unfortunately, cultures of blame create levels of remorse that lead to shame. Because shame is often intolerable, it can lead individuals and organizations to blame others rather than take responsibility for the error and thereby explore and create solutions to address the error or problem. Although there might be validity to the claim that attorneys and the media contribute to the culture of blame in the medical community, we need to take a long look in the mirror and own up to our own responsibility in perpetuating this dysfunctional culture of blame.

In recent years, The Institute of Medicine (IOM) has produced 2 reports: “To err is human” and “Crossing the quality chasm.” These reports direct the health care industry to create systems that acknowledge error and work together to solve those errors. The goal is to provide health care that is patient-centered, safe, effective, efficient, timely, and equitable. The charge of these reports is to create quality health care cultures that adopt a complex adaptive systems approach. This model responds to errors through focusing on solutions rather than blame.

In a collaborative model of care, the occasional error is accepted, not because it is desired and not because we are cavalier to the implications of this error, but because by admitting to the error, we have a chance to focus on a solution, thereby creating the possibility of a better system for those who follow. When errors are pinned on an individual, we lose focus on the core principle that an occasional error will occur, even to exceptional people. The solution is to recognize how we can protect ourselves from our humanness without losing the wonderful resource that is our humanness.

It is unlikely that, given the complexity of health care and the uniqueness of each individual’s need for treatment, that we could ever create infallible protocols. We should nevertheless use experiences like the one at Duke to improve our protocols and to learn. In that way, Jessica Santillán becomes one of our most important teachers. At the same time, we need to find ways to accept that we, as health care providers, are human, too. We might occasionally fail, even when we have done the very best that we can. We must resist the temptation to feel shamed by that acceptance and to take the all-to-easy pathway of blaming the individual rather than trying to reform the system.

To be successful, we need support. Our expectations of ourselves and of those we work with need to be changed. If we are successful, perhaps we can eventually change the expectation of the public from one that anticipates that anything less than a perfect outcome is a failure to one that understands that we have by far the best health care in the world, but it is not perfect. We have some of the best surgeons in the world, but they are not perfect. And we can appreciate them and have compassion for them when they fail, just as we had compassion for Jessica and her family.

Our future is in our hands. We are the ones who must lead the effort to change our culture. We owe it to ourselves, to the future generations of surgeons, and most of all to our patients, who entrust us every day with their lives.