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Perspective
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Moving Away From a 'Culture of Blame' in Medicine

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Perspective

Months ago, a 34-year-old hypertensive mother died as a result of spontaneous aortoclasia while doctors and nurses struggled to prevent her from miscarrying at the Third Affiliated Hospital of Peking University in China. The following day, the Department of Gynaecology and Obstetrics of that hospital was vandalized, and several doctors were attacked. While such 'medical incidents' ('*yi nao*') [1] have become frighteningly common in China [2,3], this one stands out because it involved several prestigious institutions, including the Chinese Academy of Sciences, one of the largest hospitals in the country, and the largest professional association of physicians. In the wake of the incident, these organizations have called for moving beyond the urge to blame individuals and instead to examine the medical system and creating processes and working environments to prevent such tragedies.

One of the greatest challenges to patient safety is a 'culture of blame' pervasive in medicine, particularly in rigid heirarchical cultures such as in Asia. Medical workers are scared to criticize their superiors or admit mistakes that they or colleagues have made, for fear of reprisal and blame. Instead of acknowledging mistakes, they cover them up. Such a culture is counterproductive: it impedes efforts to create a culture of mutual support and vigilance that can improve patient safety.

The healthcare industry should learn a lesson from the civil aviation industry. In its early days, that industry faced substantial safety problems; not-infrequent accidents led airline companies and the public to point the finger at particular individuals, sometimes at the expense of asking broader questions about general practices. Eventually, airline companies and regulators began to focus on how to reform the overall system to prevent mistakes and accidents. Companies set out to create a work environment in which colleagues are encouraged to report problems (real or potential) rather than hide them for fear of losing face or antagonizing the supervisor.

Such a 'safety culture' and 'reporting culture' would benefit the healthcare industry. What we need is a healthcare system where colleagues consider themselves part of a team whose members look out for one another, helping ensure that no one makes mistakes and that when (not if) they are made, they are rectified and the relevant processes modified to prevent them in the future.

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