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Shame: the elephant in the room

Managing shame is important for improving health care

In the 1960s the results of a large randomised controlled study by the University Group Diabetes Program showed that tolbutamide, virtually the only blood sugar lowering agent available at the time in pill form, was associated with a significant increase in mortality in patients who developed myocardial infarction. The obvious response from the medical profession should have been gratitude: here was an important way to improve the safety of clinical practice. But in fact the response was doubt, outrage, even legal proceedings against the investigators; the controversy went on for years. Why?

An important clue surfaced at the annual meeting of the American Diabetes Association soon after the study was published. During the discussion a practitioner stood up and said he simply could not, and would not, accept the findings, because admitting to his patients that he had been using an unsafe treatment would shame him in their eyes. Other examples of such reactions to improvement efforts are not hard to find.[1] Indeed, it is arguable that shame is the universal dark side of improvement. After all, improvement means that, however good your performance has been, it is not as good as it could be. As such, the experience of shame helps to explain why improvement—which ought to be a "no brainer"—is generally such a slow and difficult process.[2]

What is it about shame that makes it so hard to deal with? Along with embarrassment and guilt, shame is one of the emotions that motivate moral behaviour. Current thinking suggests that shame is so devastating because it goes right to the core of a person's identity, making them feel exposed, inferior, degraded; it leads to avoidance, to silence.[3] The enormous power of shame is apparent in the adoption of shaming by many human rights organisations as their principal lever for social change[4]; on the flip side lies the obvious social corrosiveness of "shameless" behaviour.

Despite its potential importance in medical life, shame has received little attention in the medical literature: a search on the term shame in Medline in November 2001 yielded only 947 references out of the millions indexed. In a sense, shame is the "elephant in the room": something so big and disturbing that we don't even see it, despite the fact that we keep bumping into it.

An important exception to this blindness to medical shame is a paper published in 1987 by the psychiatrist Aaron Lazare which reminded us that patients commonly see their diseases as defects, inadequacies, or shortcomings, and that visits to doctors' surgeries and hospitals involve potentially humiliating physical and psychological exposure.[5] Patients respond by avoiding the healthcare system, withholding information, complaining, and suing. Doctors too can feel shamed in medical encounters, which Lazare suggests contributes to dissatisfaction with clinical practice. Indeed, much of the extreme distress of doctors who are sued for malpractice appears to be attributable to the shame rather than to the financial losses. Also, who can doubt that a major concern underlying the controversy currently raging over mandatory reporting of medical errors is the fear of being shamed?

Doctors may, in fact, be particularly vulnerable to shame, since they are self selected for perfectionism when they choose to enter the profession. Moreover, the use of shaming as punishment for shortcomings and "moral errors" committed by medical students and trainees—such as lack of sufficient dedication, hard work, and a proper reverence for role obligations[6]—probably contributes further to the extreme sensitivity of doctors to shaming.

What are the lessons here for those working to improve the quality and safety of medical care? Firstly, we should recognise that shame is a powerful force in slowing or preventing improvement and that unless it is confronted and dealt with progress in improvement will be slow. Secondly, we should also recognise that shame is a fundamental human emotion and not about to go away. Once these ideas are understood, the work of mitigating and managing shame can flourish.

This work has, of course, been under way for some time. The move away from "cutting off the tail of the performance curve"—that is, getting rid of bad apples—towards "shifting the whole curve" as the basic strategy in quality improvement[7] and the recognition that medical error results as much from malfunctioning systems as from incompetent practitioners[8] are important developments in this regard. They have helped to minimise challenges to the integrity of healthcare workers and support the transformation of medicine from a culture of blame to a culture of safety.[9]

But quality improvement has another powerful tool for managing shame. Bringing issues of quality and safety out of the shadows can, by itself, remove some of the sting associated with improvement. After all, how shameful can these issues be if they are being widely shared and openly discussed?[10] Here is where reports by public bodies[8 9] and journals like *Quality and Safety in Health Care* come in. More specifically, such a

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journal supports three major elements—autonomy, mastery, and connectedness—that motivate people to learn and improve, bolstering their competence and their sense of self worth, and thus serving as antidotes to shame.[11]

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Declining altruism in medicine

Understanding medical altruism is important in workforce planning

Altruism, the performance of cooperative unselfish acts beneficial to others, has been studied in several medical contexts, including the donation of organs and genetic material and patients' participation in potentially hazardous experiments and trials.[1] Physicians' altruism towards their patients and others has been less well studied and is implicit, rather than explicit, in statements about medical professional values and attitudes. Altruism is, however, embodied in many cultural stereotypes of the "good doctor," such as John Berger's country practitioner in *A Fortunate Man*.[2]

Altruistic behaviour by physicians might include, for example, continuing to work or providing informal medical advice outside contracted hours, giving free treatment to poor patients in fee for service healthcare systems, and a general willingness to go the extra mile in professional activities. There is much evidence that many doctors work beyond their contracted hours, but there is also a growing feeling that altruism in medicine, if not dying, is at least declining.

This might be expressed, for example, in the anaesthetist's unwillingness to accept a final case on the list because the operation would run beyond the limit of the contracted session; in the general decline in home visiting rates by general practitioners; or in the recent explicit choices now made by young doctors in balancing professional and domestic commitments. Generation X is making a cool appraisal of the costs and benefits of a medical career.

Explaining the emergence and maintenance of altruistic and cooperative social behaviour has been a longstanding problem in the biological and social sciences, and there is currently intense debate about the determinants of human nature. Darwin recognised altruism as a particular difficulty for his evolutionary concept, which was based on competition and the struggle for existence. The widely accepted solution to this problem is the model of kin selection, in which cooperation is more likely to develop among genetically related individuals and which now forms part of the selfish gene view of natural selection.[3–4] Cooperative behaviour, however, is likely to be sustained only when there is either direct or indirect reciprocity, in which benevolence to one individual increases the chances of receiving help directly in return or indirectly from others.[5] Experiments involving game theory and computer simulations of these behaviours within populations have confirmed the importance of reciprocity[6] in sustaining altruism, but because reproductive success is often used as an outcome measure, these results should be applied with caution to medical populations.

It is possible to think of a number of ways in which reciprocity might sustain medical altruism. The first of these is the support and assistance rendered to doctors working under difficult circumstances. Many readers will be old enough to remember the miraculous appearance of coffee and sandwiches on hospital wards in the small hours of a long weekend on call, and the comforts of the doctors' mess that mitigated some of the miseries of frequent resident duties. Secondly, doctors have enjoyed for many years a level of social esteem accorded to few other professions. In *Captain Corelli's Mandolin*,[7] Dr Iannis derived his authority in the kapheneion (coffee house) from the experience of a life in medical practice, which also equipped him to act as a counsellor in matters of love and war. Thirdly, doctors have traditionally enjoyed material and financial security, which perhaps now is beginning to compare unfavourably with that in other career opportunities.

At a time of unprecedented mistrust between the medical profession, the public, and the media, understanding the roots of altruistic behaviour in medicine is critical. The unquestioning status traditionally accorded to healers in times of aetiological ignorance and therapeutic impotence has given way to a more sceptical and often disparaging view of doctors, now in possession of unparalleled therapeutic capabilities. Pathetic gratitude for ineffective medical interventions has been replaced by escalating demands and expectations, often fuelled by media hyperbole and an enduring public appetite for miracles. The critical role of an open and honest dialogue between doctors and patients has been emphasised in this journal,[8] but this

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