Management of shame in quality improvement

Shame: the elephant in the room

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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. It is hoped that open discussion of safety issues in *QSHC* will remove some of the shame relating to them

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

An important clue to the origins of this curious anomaly surfaced at the annual meeting of the American Diabetes Association soon after the UDGP study findings were 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]

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What is it about shame that makes it so hard to deal with? Shame, along with embarrassment and guilt, is one of the self-conscious "moral emotions"—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 as a person; although "moral" in quality, shame is also likely to be experienced in "non-moral" situations—for example, failure in performance—and is very much dependent on what other people think; it leads to avoidance, to silence. In these respects shame differs from guilt, which is largely concerned with a particular act or behaviour, is less damaging to someone's overall sense of self-worth than shame, and motivates people to restitution, confession, and apology.[3] The enormous positive 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 literature on quality improvement—indeed, in the medical literature generally. A search on the term "shame" in November 2001 yielded only 947 references, a tiny fraction of the roughly seven million articles indexed in Medline. 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 medical "shame blindness" 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 to medical shame or the fear of it by avoiding the healthcare system, withholding information, complaining, and suing. Doctors too can feel shamed in medical encounters, which Lazare suggests provokes counterhumiliation and 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 of being sued rather than to the financial losses involved. As a related issue, who can doubt that the real agenda in 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 the shortcomings of medical students, particularly during their clinical years, and for "moral errors" committed by registrars, such as lack of sufficient dedication, hard work, and a proper reverence for role obligations,[6] very likely contributes further to the extreme sensitivity of doctors to shaming.

What are some of the lessons here for those working to improve the quality and safety of medical care? The first is the importance of recognising that there actually is a problem: that shame is a powerful force in slowing or preventing improvement; that unless and until shame is confronted and dealt with, progress in improvement will be slow. The second is the recognition that shame is a fundamental human emotion and is not about to go away, no matter how successful we are at handling it. Once these basic ideas are firmly rooted, the work of mitigating and managing shame can really 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"—and 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] can be seen as important developments in this regard. These new ways of reframing the issues of improvement and safety 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 (witness the recent article in *Trustee* magazine[10])? Here is where reports by public bodies[8 9] come in, and where a journal like *Quality and Safety in Health Care*—with its new title, increased focus on safety as well as quality, and the BMJ Publishing Group's co-ownership of the title with IHI—can make a huge difference. More specifically, such a 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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The autonomy under consideration here is not the ugly variety of blind self-sufficiency that isolates and divides; rather, it is the sense that the learning and the improvement belong to the learner, rather than being imposed from outside. Getting the information on improvement that they need, when they need it, and out of their own dedicated journal certainly supports the readers' sense of autonomy. High quality, theoretically grounded, practical journal content can certainly contribute to the mastery of the readers—knowing something, knowing how to do it, and how to do it well. And knowing as they read their journal that hundreds or thousands of like-minded people are reading the same material at roughly the same time certainly creates a sense of connectedness—instant community, if you will.

May *Quality and Safety in Health Care* live long and prosper, and may it help to capture and tame the elephant in the room. It would be a real shame if it didn't.

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Patient safety

The end of the beginning: the strategic approach to patient safety research

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Research into patient safety has undergone a period of rapid acceleration since the decision of the US AHRQ to make a specific commitment to fund research into systems for improving patient safety

Patient safety is not a new issue and has been the subject of research internationally for decades. Funding for patient safety in the US has been around for some time and, in fact, work cited in the Institute of Medicine (IOM)'s landmark report[1] was funded by the Agency for Healthcare Research and Quality (AHRQ). Supported research has investigated preventable adverse drug events,[2] the role of systems failures in the aetiology of medical errors,[3] and the effects of the healthcare workforce on safety.[4] Other funding in Australia and the UK has advanced our knowledge of patient safety considerably.

The funding of these important studies, however, was not based on any strategic commitment to addressing the patient safety challenge but, instead, the approach of research funders to patient safety had been an opportunistic one. The agencies solicited bright patient safety researchers employing sound methodology to address compelling issues. Funding was awarded on the basis of the ability to compete successfully against a wide range of healthcare issues. As a result, the number of researchers involved, the armamentarium of methodologies, and the scope of the research has been relatively limited.

BACKGROUND

In 1999 the US AHRQ made the decision to take a different, more strategic approach to patient safety research. The Agency's fiscal year 2000 budget included a specific commitment to fund research in patient safety through a modest $2 million investment in research on systems related best practices in improving patient safety.[5] It was hoped that this initial foray into funding patient safety research would slowly evolve into a sustained initiative which would gradually grow in terms of both importance and investment.

The IOM report,[1] however, dramatically changed the deliberate but slow transition to a more strategic approach in funding patient research in the US. The report highlighted the urgent need to develop an evidentiary base for safety improvement through research. In response to the IOM report, the President asked the federal government's Quality Interagency Coordination Task Force (QuIC) to draft a comprehensive plan to address the issues of medical errors and patient safety.[6] Both the IOM and QuIC reports called for a substantial targeted investment in patient safety research which became a reality with the appropriation of $50 million for patient safety research in AHRQ's fiscal year 2001 budget.

"Be careful what you wish for"

The myriad of challenges in affecting the strategic transformation of patient safety research have, at times, suggested the adage of "be careful what you wish for . . .". Because patient safety research was not a new field, agenda setting and the mechanisms to support research had to be cognisant of its history. Existing literature from the safety field, for example, demonstrated the value of a multidisciplinary approach to patient safety research demanding novel tactics to promote multidisciplinary teams of researchers. The relative paucity of funding had led to a situation where there were relatively few established researchers in