It has become common knowledge that healthcare takes place in complex settings that are fraught with the potential for error. More than this, it is becoming a commonplace understanding that error will occur in hospitals, and that some of those errors will inflict harm on patients and their families. The Institute of Medicine report *To Err Is Human,* describes error as involving multiple aspects with the most obvious being the “sharp end”—the individual who erroneously acted or failed to act is at this sharp end and has historically taken the blame for any harm that ensues.

In an effort to expose the full story of error, the Institute of Medicine report emphasizes the importance of latent errors: those system characteristics that not only make errors possible, but in some cases favor and encourage work patterns that inevitably result in mistakes.

Partly due to this attention to the complex interactions of individuals and systems, and partly because of mandates from external regulatory agencies, acute care hospitals are becoming more safety conscious and implementing new safety standards. These standards are attentive to both individual habits and system qualities that contribute to mistakes. Rather than blame the individual or individuals at the “sharp end” of the error, the new thinking about medical mistakes or mishaps shifts the emphasis to an examination and improvement of the underlying system.

In this column I would like to discuss blame, accountability, and responsibility, and explore how responsibility without blame might be fostered in communities of practice that promote the professional development of nurses.

**Accountability and System Audits**

This new era of “no blame” has prompted some nurses, physicians, and members of the lay public to wonder about the role of personal responsibility. Is error always the system’s fault? What about personal carelessness and sloppy practice? Is it ever appropriate to blame an individual for an error that is the result of his or her own carelessness or poor judgment? The National Council of State Boards of Nursing has taken up these questions and built a taxonomy of nursing practice breakdown that differentiates between errors made from willful negligence and intentional misconduct and those slips that occur even with the most conscientious of practitioners due to lack of system support. These different categories of error demand different responses from providers and institutions.

But it is sometimes difficult for nurses to distinguish between the institution’s response to willful negligence and its response to system problems. Take, for example, a nurse who bypasses an electronic warning and accidentally programs an intravenous (IV) pump to deliver an overdose of heparin. A second nurse performs an “independent double check” of the programming and overlooks the error. As a result the patient suffers an intracerebral hemorrhage. Is this willful negligence on the part of these 2 nurses? Their signatures are on the documentation indicating their accountability for the dose given, but are they responsible for their actions and are the actions blameworthy?

Institutions audit performance partly to target system problems in need of repair and to decide on
the appropriate response to an error. The heparin dose error described above should prompt an audit to uncover any system problems that may have contributed to this tragic outcome. If an audit of the IV pumps reveals that it is common for nurses to bypass alert messages that come up when they are programming the pumps, perhaps there is a problem with the system that delivers the messages. For example, if IV pumps commonly give nuisance warnings—warnings that must be bypassed in order to program the pump to deliver the right dose—nurses will develop “alarm fatigue” and become accustomed to bypassing warnings, not realizing when the warning is serious. In this situation the nurses cannot be blamed for bypassing the warning because the warning system trained them to do it. The logical system improvement would be to eliminate nuisance warnings.

The best use of audits is to draw attention to system-wide problems. But audits also are used to enforce individual provider accountability. In some situations, when an error is discovered in the process of an audit, the error can be traced to the individual providers involved who are then held accountable. Thus the nurses who participated in the heparin dose error might be called upon to account for their mistake, explain the circumstances in which it occurred, and speculate as to contributing factors. This kind of accountability is important for maintaining a safe environment. But regardless of the intent or the outcome, being asked to answer for your actions can be a frightening and difficult experience, especially if those actions resulted in harm to a patient.

Holding nurses accountable is not intended to be punitive, but some nurses perceive it as such when they are asked to respond to questions from management or external regulators, such as their state board of nursing. This perception, combined with poor educational preparation in articulating their concerns and making an argument, puts the process of personal accountability at risk. That is, it could become just another way to place blame.

### Responsibility and Professional Practice

In contrast to the blame view of accountability, a discussion of professional education by Michael Eraut describes professional practice as autonomous and self-regulating, with individual professionals being primarily accountable to themselves. Being accountable in this way means taking on an identity and internalizing notions of good practice. Professional education should inculcate the nursing student with this internal sense of responsibility, which becomes a moral compass and tells the nurse how to respond in particular situations.

Accountability of this sort is not only measured against external “benchmarks” but is guided largely by the professional’s own understandings of good practice. These “internal benchmarks” are provided by the larger practice community and instilled in the new nurse as she or he enters the practice.

Bernard Williams describes a similar idea as the “internalized other.” Although most of Williams’ discussion is concerned with the ethics of ancient Greece, he sees strong parallels with modern Western notions of responsibility. One similarity has to do with the uses of shame: a sense of shame is generated when one’s actions conflict with one’s internalized ideal of ethical behavior. The internalized ideal comes from the community in which one is immersed; for nurses, this would be a community of practice with a like-minded commitment to service. Feeling shame helps us realize that our behavior is culpable, that we transgressed the boundaries set by our community.

Eraut is interested in the education of all professions. He asserts that professional accountability should be drawn from a commitment to service and should include the following:

- A moral commitment to serve the interests of clients; a professional obligation to self-monitor and to periodically review the effectiveness of one’s practice; a professional obligation to expand one’s repertoire, to reflect on one’s experience and to develop one’s expertise; an obligation that is professional as well as contractual to contribute to the quality

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**About the Author**

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The safety movement’s emphasis on blame-free error and the elimination of shame by shifting inquiry to the system is an important step toward a safer hospital environment.

Accountability, as it is taken up in many health care institutions and understood by many nurses, involves giving evidence on one’s own behalf to justify one’s actions to an external judge. Instead of this focus on an external judge, Eraut believes, and Williams’ writing also supports the notion, that the professional nurse should have her or his own internal judge to answer to. The professional nurse should possess an internalized part of the practice community.

When called to account for their actions, the nurses involved in the heparin dose error should have already demanded an accounting from themselves. They might describe the problem with nuisance alarms and their becoming accustomed to bypassing these warnings. They might also explain that it is unreasonable and unrealistic to expect a nurse who is busy and distracted by her own complex assignments to give her attention to an independent double-check.

But the nurses would also be ready to put forward new ideas for making the system and their own practice safer. This is a way to account for the error that shifts the focus away from blaming the individual nurses and toward correcting systems that are designed to promote error. But this also allows the nurses to take responsibility for the error by acknowledging their roles as professionals within the system. The nurses involved in the error should share their stories in detail with other providers who may be at risk for similar errors and then lead an interdisciplinary team in solving the system issues.

Blame, Shame, and Punishment

It is now commonly understood that if providers fear a punitive response from management they will be more likely to hide their errors. The safety movement’s emphasis on blame-free error and the elimination of shame by shifting inquiry to the system is an important step toward a safer hospital environment. But is it possible to stay away from blame and punishment without giving up professional responsibility? The example of the heparin dose error illustrates one possible way nurses can maintain professional responsibility for their mistakes by articulating problems and participating in system improvements.

In the kind of practice Eraut and Williams describe, professional nurses would be accountable to themselves first. They would audit their own practice with attention to identifying personal attributes and system characteristics that promote error and contribute to an unsafe environment. Shifting the response to error into the hands of the providers will require a truly professional practice community with rewards and punishments internal to that practice.

FINANCIAL DISCLOSURES
None reported.

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Error, Blame, and Professional Responsibility
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