Error, injustice, and physician wellbeing

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Healthcare is riddled with injustice and inequity. Clinicians strive to create better, more just systems, and experience deep moral distress when we are unable to do this. We care for the broken but expect perfection of ourselves. Limitless need combined with imperfect systems and impossible expectations of ourselves is the perfect recipe for burned out and broken doctors. In a review of physician suicides in the United States during the 20th Century, Legha argued that despite a growing sense of the importance of physician well-being, the expectations of perfection and the difficulties of accepting personal vulnerability remained major unresolved drivers of profound physician distress. Ethics and justice must be questions not only in relation to patient care but for the selfcare of healthcare practitioners and the systems in which they

work. Here we explore the injustice that arises from two major and longstanding sources of clinician distress: the experience of clinical uncertainty, and coping with errors in practice.

When writing about his early medical experiences, Siddhartha Mukherjee commented he 'never expected medicine to be such a lawless, uncertain world.' Atul Gawande noted in his book *Complications* that 'medicine's ground state is uncertainty.' He observes that this experience is 'wrenching' for patients, 'difficult' for doctors, and that it is 'hard to grasp how deeply uncertainty runs'. Rachel Clarke, writing of her experience as a young doctor in *Your Life in My Hands*, described uncertainty in acute decision-making: 'As a newly minted doctor, I knew twenty-eight causes of pancreatitis, the names of all two hundred and six bones in the human body, the neurophysiology of stress and fear, but not - not even remotely - how to make the emergency decisions that, if I got them wrong, might end up being the death of someone.'

Uncertainty is also intrinsically linked with the risks and experience of error. David Hilfiker wrote a landmark description of the trauma of being human and being a clinician, in his book *Healing the Wounds*. His words from that book still resonate strongly now: 'Because doctors do not discuss their mistakes, I do not know how other physicians come to terms with theirs'; 'we see the horror of our mistakes, yet we cannot deal with their enormous emotional impact'; 'A physician is even less prepared to deal with his mistakes than is the average person'. He comments that continuous decision-making by physicians in the care of ill patients makes even determining if a mistake has been made challenging. It can be hard to know at any given moment whether small and large decisions, made hours or days ago, could contribute adversely to a current situation. Danielle Ofri, writing in *How Doctors Feel*, described the necessity of reaching an 'emotional armistice' with the fear and anxiety of being a clinician, reflecting that the wrestling with lack of knowledge and fear of making errors has both an emotional cost but also drives clinicians to better themselves and their knowledge. However, the internalisation of error is such that the negative emotion does not attach to the act, but to the person. As Atul Gawande wrote in the context of personal error, 'I felt a sense of shame like a burning ulcer. This was not guilt: guilt is what you feel when you have done something wrong. What I felt was shame: I was what was wrong.'

We teach how to rationally approach diagnostic uncertainties, but not what it is like to carry the emotional burden of uncertainty or of error. Aristotle's concepts of virtue as being practical, and about doing good, pervade the clinical identity. The philosopher Quassim Cassam identified a list of core virtues of the clinical generalist, including empathy, humility, testimonial justice, and situational judgement. The process of becoming a clinician, and continuing to develop in lifelong practice, forms a specific social identity so that clinicians act from shared values and behave in accordance with these shared beliefs. However, striving to live up to these ideals presents huge challenges. Hilfiker, examining his own distress and its relationship to the challenges of maintaining the physician identity and meeting huge patient need, wrote 'Furthermore, as a physician I was defined by society, by the medical profession, and by my own expectations […] When this pressure was combined with the roller-coaster of pressures of the job, the emotional burden often seemed overwhelming. [...] Not surprisingly, I could not sustain the degree of openness required to go from deepest need to deepest need…'.

The difficulties of discussing the personal experience error and uncertainty create a state of injustice. Clinicians lack formal and informal places in which these experiences are spoken of, and often find it unnatural and uncomfortable to share the emotional work and challenges presented. The injustice associated with suppression of voices, knowledge and experience has been termed epistemic injustice (epistemology refers to theories of knowledge). There are two broad forms of epistemic injustice. The first is 'testimonial injustice', in which someone's voice and knowledge are ignored or disavowed for some reason of bias. Examples of this would include a misogynistic or racist failure to listen to or value another's knowledge. The second type of epistemic injustice occurs when there is no shared language or insufficient shared concepts to permit interpretation of experience, such as occurred to women trying to speak of postnatal depression before that diagnostic label existed. This is referred to as hermeneutical injustice, where hermeneutics refers to interpretation of knowledge. The discussion of epistemic injustice in medicine appropriately focuses on systems and clinicians that ignore, miss, or fail to hear the voices and knowledge of those they endeavour to care for. (See, for instance, work by Carel and Kidd.) This can sometimes be the result of a physician's insensitivity, or it

might also happen without fault on the part of the hard-pressed physician. Whether or not there is any fault at stake, however, what is important is that there are effective ways of addressing insensitivities and mistakes. However, medical traditions, legal and care systems fail to generate a just environment in which the lived personal experience of uncertainty and error can easily be spoken of without stigmatising the clinician. The discursive context is akin to one of taboo, and it is created by the profession's collusion with a fantasised idea of medical omniscience that sets all real doctors up for a fall. And so all too often there is nothing for it but to play along with the fantasised superhuman standard, hope nothing ever goes wrong, and suffer the deep shame that Gawande speaks of when it does. This injustice may contribute powerfully to the clinician experience of moral distress. When it happens, clinicians are all too often left alone to negotiate the terrain alone.

To address and change this, we need to shake off the twin fantasies of omniscience and infallibility. We need to equip clinicians with the tools to cope with uncertainty and error without shame, and without professional taboo, and embed them in organisations and systems that support these processes. This is not just about addressing causes of burn-out, but about addressing the underlying clinician identities and beliefs that subconsciously but so powerfully shape clinician behaviours. We should train ourselves in self-care and care of each other. Self-compassion is associated with lower rates of burn-out, tolerance of uncertainty, and workload stress. We propose that this may also be complemented by self-justice: a state of mindful self-analysis that examines the need to be just to ourselves as well as compassionate to ourselves. An understanding of justice applied with compassion will give clinicians the reasons needed to be kind to themselves and others, without reducing the rigor with which they practice their profession. It is right and just and necessary to create the spaces and processes and systems that foster understanding of uncertainty, error and support of clinicians engaged in work that permeates much of their identity and often most of their waking hours. . Arthur Kleinman talked of remaining *present* as a moral act at the heart of physician responsibility. Present to our needs, uncertainties, successes and failings, and prepared to speak of them and listen to those of others, we become more complete and more able to provide a tender hand to our colleagues and our patients.

It is therefore profoundly ironic that a profession that is highly regulated, held to ethical standards, and has at its heart the care of other human beings, fails to articulate well for the care of its own members. There is some evidence of improvement, with a drive to better error reporting systems, more supportive investigations of errors and a willingness to review system failures alongside personal error. However, rates of moral distress, burn out and suicide show how much more we need to do. The personal experience of uncertainty and error is difficult to articulate in the context of professional medical practice, with the consequence that we lack a fair and just framework in which to examine these important causes of burnout. A just, ethical practice would be one in which there is transparency, candour, and a duty of care that clinicians extend to their colleagues, and that regulators address and support. In such a framework, a transparent, supportive review of error would be easier, and good clinicians who make mistakes (and surely, all clinicians make mistakes) will be better cared for and better placed to support those who suffer as a consequence of the error.

In his 1971 work *A Theory of Justice*, John Rawls proposed a thought experiment in which participants gathered to design social and political systems, but the participants worked behind a veil of ignorance. They would not know what position they would assume in society, what gender, what race, what country. If medical care was designed behind such a veil, without knowing one's status as patient or clinician or ill or burnt out practitioner, the model might look not just at how clinicians care for patients, but how they care about themselves.

At a moment when physicians and health care providers are stretched sometimes beyond limits by a global pandemic, we are reminded of the immediate need to care for all health care providers concurrently. As noted in the *House of God*, 'How can we care for our patients, if'n nobody cares for us?'

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Further reading

Wilson, A, Millard, C, Sabroe, I. Physician narratives of illness. The Lancet. 2019;394(10192):20-21.

Legha, RK. A history of physician suicide in America. J Med Human. 2012;33(4):219-244.

Cruess, SR., Cruess, RL, Steinert, Y. Supporting the development of a professional identity: General principles. Med Teach 2019;41(6):641-649.

Hilfiker, D. Healing the Wounds. New York: Fordham University Press; 1998.

Lyons, B., M. Gibson, and L. Dolezal. Stories of shame. The Lancet. 2018;391(10130):1568-1569.

Dzeng, E., and R. M. Wachter, RM. Ethics in Conflict: Moral Distress as a Root Cause of Burnout. J Gen Intern Med. 2020;35(2):409-411.

Fricker, M. 2007. Epistemic Injustice: Power and the Ethics of Knowing. Oxford: Oxford University Press; 2007.

Carel, H. and Kidd, I. J. Epistemic injustice in healthcare: A philosophical analysis. Medicine, Health Care and Philosophy 17(4) 2014; 529-40.

Kleinman A, The Art of Medicine: Presence. The Lancet. 2017;389:2466-2667.

Hall-Flavin DK: The Quality of Mercy. In: Brannigan MC ed.. Spirituality and Deep Connectedness: Views in Being Fully Human. Lanham, MD: Lexington Books; 2018:49-66

Clarke, R. Your Life In My Hands - A Junior Doctor's Story. John Blake Publishing Ltd; 2017.

Ofri, D. When We Do Harm. A Doctor Confronts Medical Error. Beacon Press; 2020.

Cassam, Q. Professional Virtues in Modern Medicine. 2019.eBook at https://www.medicalvirtues.co.uk