SHAME IN MEDICINE: THE LOST FOREST

EPISODE GUIDE

EPISODE 6. THE MISTAKE

the NOCTURNISTS

How to Use This Guide

Though shame is everywhere in medicine, the topic is taboo, which can make it difficult to discuss. To help, we've prepared discussion guides for each episode of our audio documentary series, *Shame in Medicine: The Lost Forest*, to facilitate conversations between friends, colleagues, and leaders.

This discussion guide is for Episode 6. The Mistake

You'll find:

- Episode summary
- Notes from behind the scenes
- Discussion questions
- Additional resources

Lastly, talking about shame can be challenging, emotionally and interpersonally. Please feel free to use our facilitator toolkit for leading and organizing conversations around shame. You can find additional resources at thenocturnists-shame.org/engage.

Illustration by Beppe Conti

Episode 6. "The Mistake" Summary

For most clinicians, the idea of harming a patient is a worst nightmare. But in a high-stakes profession, practiced by humans in a dysfunctional system, errors are nearly inevitable. So how do we deal with the shame that follows?

Behind the Scenes

From the very earliest days of this project, we knew we wanted to create an episode about shame and medical error. The first cut of this episode was so emotionally devastating it was almost painful to listen to – which speaks volumes to the challenge and responsibility of working in a high-stakes profession like medicine. In our team conversations, we often referred to the concept of the “second victim,” a term coined by Dr. Albert Wu in 2000, which helps illuminate and address the severe psychological impact of medical error on clinicians. Since Wu’s article was published, the term “second victim” has been criticized by some who argue that it minimizes the fundamentally different impacts that error has on patients and families compared to clinicians. We sought in this episode to both affirm the humanity and emotionality of physicians, and acknowledge that these exist in concert with, not in opposition to, the struggles and pain of patients and their families.

Discussion Questions

1. Which parts of this episode did you connect with, and why?

2. What narratives have you been taught about error in medicine? How has this affected the way in which you think about your own practice? How could medical education be designed to teach the value behind mistakes (as opposed to the hidden curriculum that mistakes = personal shortcomings)?

3. Think about a time when you were involved in a medical error. What was your experience? Who did you lean on for support? What would be a part of your “emergency plan” the next time you make a mistake?

4. When we do make mistakes, how do we navigate the tension between individual responsibility and systemic issues?

5. How might we create more space in our culture to talk about shame and error? What are ways in which making mistakes and coping with them can be a formalized part of training?

A Trainee Reflects on Episode 6. "The Mistake"

Reflection by a Resident

Listening to this episode was at once both incredibly comforting and profoundly terrifying. I was comforted by the fact that I wasn't alone in the utterly unpleasant concoction of guilt, self-doubt and self-hatred that seeped through my entire being every time I made mistake as I started residency. The more I allowed that mixture to brew – the more isolated I felt. To hear my fellow colleagues in medicine (attendings no less) share heartbreaking (yet all too familiar) descriptions of the stupor they found themselves after their mistakes brought a much-needed relief. Their reflections helped me start to internalize that I am anything but alone in the medical errors I have made. However, given I am acutely aware that with more responsibility will come more mistakes – this episode sent my mind spiraling about all the future mistakes ahead of me. The problem solver in me makes me wonder – I know I will make many, many more mistakes, so what "emergency plan" (as one of the speakers eloquently put it) can I lay out for myself when they happen?

The incident the IR attending shared with us about accidentally puncturing the patient's heart struck me in a way I didn't anticipate. What was most surprising to me about that story was not the mistake itself, but rather that the attending immediately disclosed his error to the patient and their family, without talking to risk management. He told them plain and simple – he made a mistake, how exactly he made the error, and he was sorry. In the aftermath, at least from what was shared in the episode, it seems the patient and their family moved on. They saw this IR attending as what he was – a human being – and moved on. In our day-to-day non-work, non-medical lives – when we make a mistake that impacts a person that trusts us and we care about – don't we apologize to them directly? And, most of the time, doesn't that person end up forgiving us? I strongly believe that a significant propagator of shame around medical errors is the teaching that we are to firmly draw "personal barriers," with patients. Granted there are some basic barriers that need to be drawn for the protection of all parties, but at what point did these barriers make us out to be these superhuman entities that were programmed for 100% success? If I was a patient and was taken care of by a provider that was never once vulnerable with me, I would of course be frustrated with them when I found out they made a mistake. If the expectation is 100% success, anything less is met with overwhelming disappointment.
(Continued on next page.)

A Trainee Reflects on Episode 6. "The Mistake" *(cont)*

I have thus started to try to balance the act of not only being confident with my patients about my medical assessments and plans, but also appropriately vulnerable so that they can see my limitations. Sometimes that sounds like me saying something as simple as, “It’s 9am and I am on my 3rd cup of coffee!” I’ll be the first to admit my “n” is pretty low compared to my senior colleagues – but so far, that’s worked! That outflow of vulnerability my patients are receiving engenders an understanding of my limitations as a human being.

At this point, naturally, the argument that 100% success should be the expectation when human lives are at stake emerges. But realistically, should it? As human beings, we are all inherently fallible. Nothing makes us less so. Not as on organic chemistry in pre-med, not 250+ scores on Step 1 or 2, not perfect OSCE grades. Yet again and again in medical education we are fed this lie that perfection is and has been attained by running the race of “who can make the least mistakes?” So when it comes to my emergency plan I’ll remind myself of two things – 1) I am equally as likely to make mistakes now as I was before medical school and 2) vulnerability with patients allows for realistic expectations of me. So, when the time comes that I make my next mistake – my patient will hopefully attribute that to the inevitability of my humanity. And maybe, just maybe, one day I’ll see the inevitability of my humanity for what it is too. It doesn’t make me less so, or less than, it makes me – me.

Resources

The below resources are specific to episode 6, “The Mistake.” To learn more about shame in medical culture, you can find recommended resources here.

Read:

- Clarkson M D. Haskell H. Hemmelgarn C. Skolnik P J. Abandon the term “second victim.” BMJ. 2019.
- Davies O, Dolezal L, Bynum WE IV, Wu C., and Berry H. Needlestick. New England Journal of Medicine. 2022.
- Mumby H. The Shame Spiral. The Shame Conversation. 2022.
- Ofri D. Ashamed to Admit It: Owning up to Medical Error. Health Affairs. 2010.
- Ofri D. My Near Miss. New York Times. 2013.
- Ofri D. When We Do Harm: A Doctor Confronts Medical Error. Boston, Beacon Press. 2020.
- Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. BMJ. 2000.
- Zabari ML. Southern NL. Effects of shame and guilt on error reporting among obstetric clinicians. Journal of Obstetric, Gynecologic, & Neonatal Nursing: Clinical Scholarship for the Care of Women, Childbearing Families, & Newborns. 2018.

Watch:

- Goldman B. Doctors make mistakes. Can we talk about that? TEDxToronto 2010.
- Ofri D. Deconstructing Perfection. TEDMED 2015.

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