

# Topic 3: Stop the blame culture!

Prof Dr. Chew Keng Sheng  
Faculty of Medicine and Health Sciences,  
Universiti Malaysia Sarawak

# Objective

- By the end of this lecture, the learners will be able to
  1. Explain the need to stop the blame game when things go wrong in a complex organization
  2. Describe the importance of adopting a system approach rather than a person approach in solving problems within a complex organization

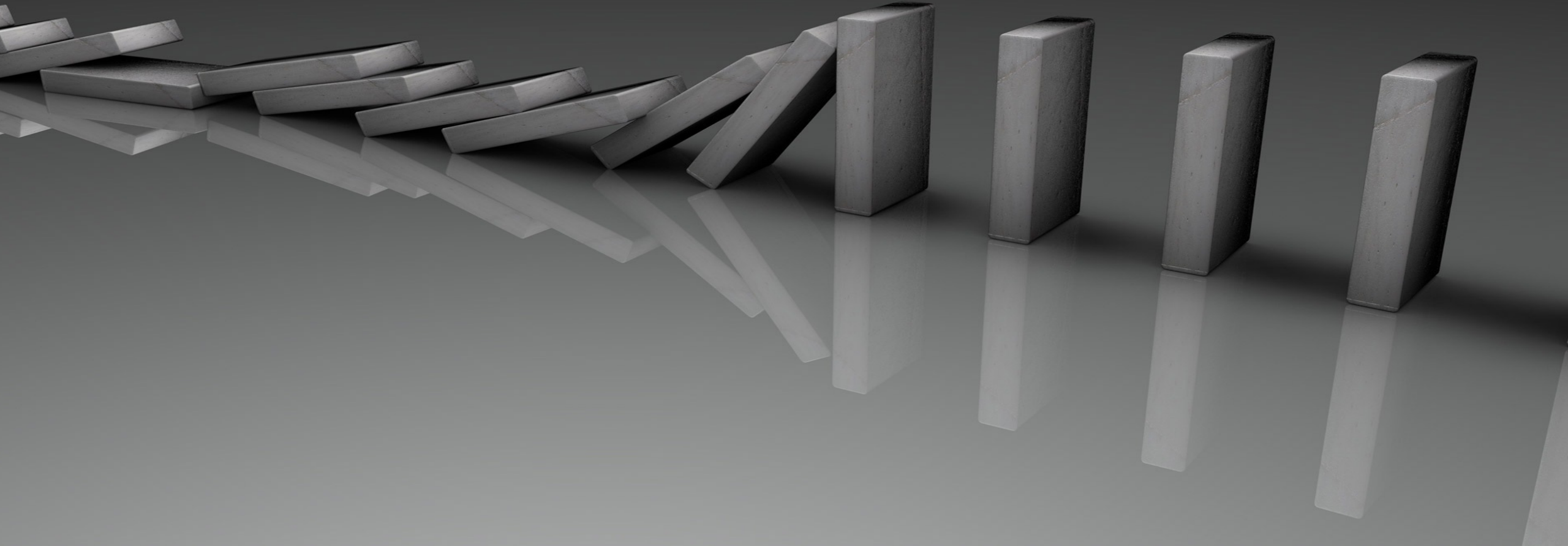
# Why do we blame?

- Human nature to blame someone, because emotionally satisfying for everyone else involved if there is someone to blame
- Belief that punitive action sends a message that errors are unacceptable
- Healthcare providers should accept responsibility as part of their training and code of practice

# Stop the blame game

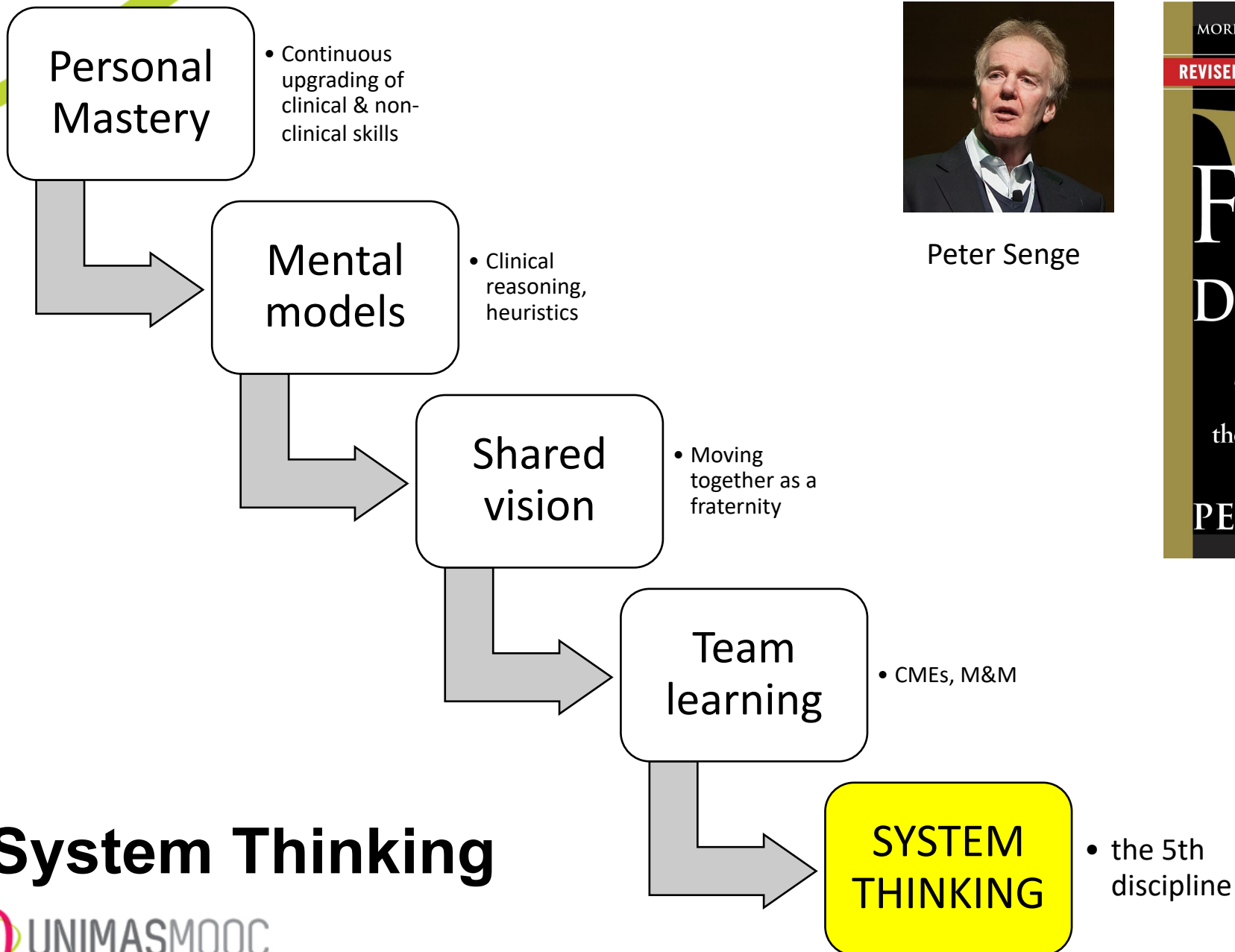
- 1970s, Turner, a sociologist – “chain of events” is critical to understanding causes of an accident
- 1984, Charles Perrow – wrote about the need to stop pointing the finger (‘normal accident theory’)
- 1997 - James Reason – hindsight bias – people do not intend for anything to go wrong and generally do what seems right at that time although they may be blinded to the consequences

**Accidents are often the result of multiple factors, not single, isolated factor.**

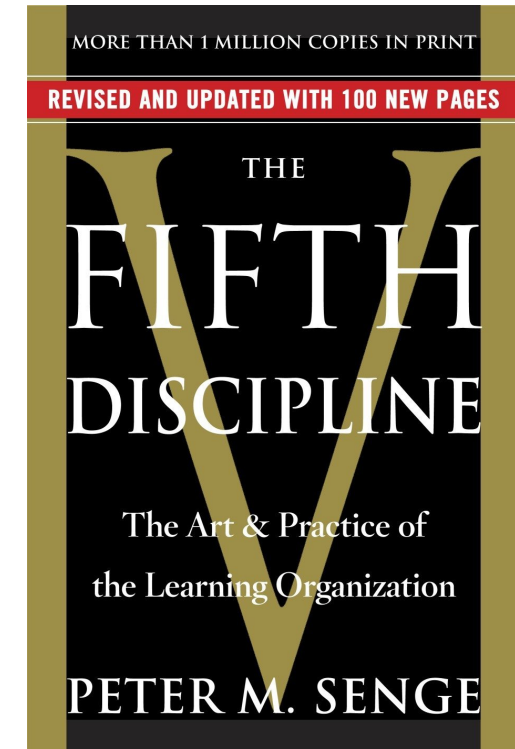


# From Person Approach to System Approach

- James Reason – latent human errors are more important than technical failures
- A “system” means there is 2 or more interacting parts forming a unified whole
- Multiple elements in the system approach:
  - Patient factors
  - Provider factors
  - Task factors
  - Technology and tool factors



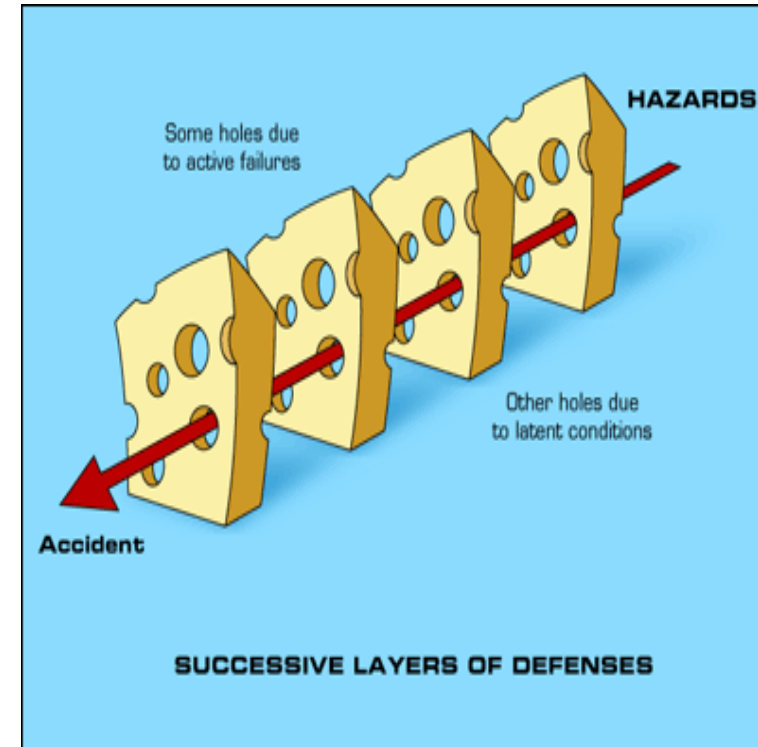
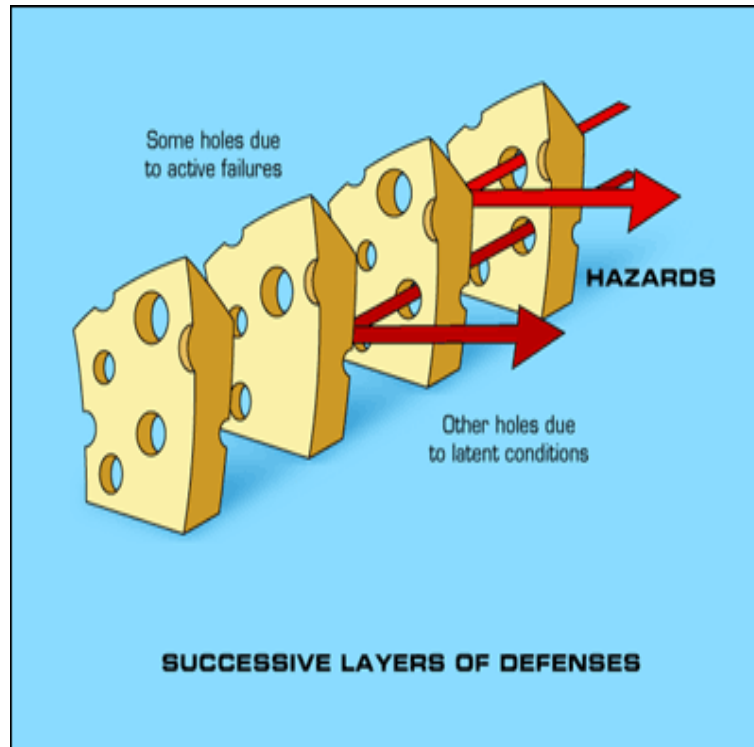
Peter Senge



## System Thinking



# James Reason's Swiss Cheese Model





# Humans are not machines!



**The fallibility of humans**

- Humans can be unpredictable, with limited ability to process information
- Miller (1956) - the working memory capable of holding 7 (+/-2) items at a time

# Conclusion

- Patient safety is a responsibility of all
- An active error is usually not the result of a single fault in the system or an individual, but a multiple or series of faults in the system
- We need to move away from blaming an individual for the errors made to addressing the deeper issues in the system
- After all, humans are fallible