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Title: Exploring Distress Caused by Blame for a Negative Patient Outcome

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Abstract

Title: Exploring distress caused by blame for a negative patient outcome

Objective: To explore blame-related distress.

Background: No research exists describing the incidence, characteristics of consequences of blame.

Methods: Survey research was used to explore the incidence, characteristics and consequences of the distress caused by blame in the workplace.

Results: Blame-related distress is prevalent among intensive care and oncology staff. Participants reported an organizational impact to blame-related distress in terms of staff morale, turnover and employee health. Management, physicians and peers were the most frequently cited source of blame.

Conclusions: A proposed model is described to relate blame to other similar constructs.

Moral distress, burnout, compassion fatigue, lateral violence, civility, and 2nd victim syndrome result in distress in the workplace and have been previously studied and described [1]. Each of these situations may cause psychological sequelae such as stress, depression, avoidance behaviors and sleep disturbances resulting in human resource consequences such as absenteeism and turnover [1-6]. Similarly, blame is thought to affect patient and workplace safety [7]. Blame-free work environments are advocated [7]. However, studies looking directly at the effect of blame in the workplace have not been reported. It was hypothesized that blame-related distress (B-RD) was similar to moral distress (MD).

The purpose of this research was to explore the incidence, characteristics, and consequences of B-RD. No known tool had been previously designed to study blame. Therefore, to study blame a new tool was indicated. The B-RD Survey was constructed, validated and then administered using audience response clickers (ARCs) during regional and national nursing oncology and intensive care (ICU) seminars.

Methods

Experts in the field of MD were consulted for feedback on project design and implementation. While tools exist to measure MD [8-10], no known tool had been previously designed to study blame-related moral distress. The Moral Distress Scale-Revised (MDS-R) measures the root causes of MD. MD prevents a nurse from taking action and exploring distress caused by inaction. Blame occurs after taking action. Therefore, a new survey tool was indicated and created for use in this study following institutional review board approval. The survey questions were derived from the literature on blame plus the related topics as described above. Multiple-choice questions were constructed to answer 7 hypotheses generated from the literature review. (Table 1) Descriptive questions were included to determine the incidence of MD, the incidence of B-RD, occupation at the time of blame, source of blame, and intensity of B-RD. Descriptive questions were asked regarding usefulness and availability of training and resources to help deal with an event leading to MD.

Questions were modified for use with audience-response clickers (ARCs). The technology was limited to single choice answers. The questions were iteratively subjected to construct and content validation by a panel of 3 doctorally-prepared nurse content experts in survey design and MD who scored each question for clarity and

relevance. Thirteen nurses and 1 physician also scored the questions for clarity. Nurses with English as 2nd language in Spanish and Tagalog, were expected to participate in the survey and were intentionally included to assure the sentence structure would not have double meaning between languages. One nurse, who had personal experience with blame, provided additional questions that were also validated.

It was determined a priori to accept 80% agreement on the wording of the questions. After 3 rounds consensus was achieved. Content experts also reviewed and approved the formatting on the slides prior to use.

At the beginning of the lectures the participants were informed of the intent to collect data for the purposes of research and a consent letter was reviewed verbally. Each attendee was issued a clicker at the start of class. An introductory question prior to the beginning of the research asked each person in the room to click A to provide the denominator for the number of people in the room. Prior to asking the B-RD survey questions, the investigator presented the definitions of MD, compassion fatigue, burnout, lateral violence, civility/incivility, and 2nd victim syndrome. A definition-of-terms sheet was distributed. The participants could refer to this when answering the questions regarding B-RD.

Sample

A total of 171 participants were offered inclusion into the study (76 oncology, 95 ICU), 157 (68 oncology, 89 ICU) consented. Supplemental digital content #1 demonstrates distribution of healthcare roles for the participants.

Results

Because participants could answer all or some questions, the sample size answering each question fluctuated and the response rate varied as a result. The demographics are reported given the number of responses received for that question. Missing data were not replaced. Data were analyzed using descriptive statistics, Mann-Whitney U, Spearman Rho, or chi square as indicated by hypothesis and reported in Table 1. (See Supplemental Digital Content 4 for expanded version of this table).   No significant difference was seen between ICU and oncology respondents for any question, therefore the results are reported for the total sample. One question on self-blame question was

constructed for use with the ICU participants only based upon feedback by the oncology respondents who were sampled first.

Construct validity was further tested through hypothesis testing to evaluate the similarities and differences between MD and B-RD. Table 1 reports the results of hypothesis testing. The attributes of B-RD were very similar to, but not equal to MD.

Incidence of MD

Moral distress was experienced by 76.4% ($n = 120$) of 157 of study participants. Moral distress was experienced more than once in 67% ($n = 101$) of respondents. The MDS-R was designed to capture the average level of MD intensity looking back over the last 2 weeks. The level of intensity at the time of the survey averaged 3.1 (Range 1 - 10, $SD = 2.2$).

Incidence of Blame

Blame for a negative patient outcome was experienced by 50% ($n = 78$) of respondents. The B-RD level experienced at the time of being blamed was recalled as a mean of 6.10 (Range 0 - 10, $SD = 2.55$) on a 0-10 VAS. The median length of time since the blame occurred was in the range of 1 – 5 years. Supplemental digital content #2 describes the distribution of B-RD intensity. The distress was still present in 36% ($n = 22$) of respondents. For those respondents whose B-RD had resolved, supplemental digital content #3 reports the length of time to resolution.

Sources of Blame and Resources

Participants could select more than 1 choice for the source of blame. Management, physicians, staff and the family of the patient were reported as the major sources of blame (Figure 1). Participants selected which resources they found useful from a list (Figure 2). They could select more than 1 response. Co-workers, friends and family were considered by the vast majority to be more useful than other resources.

Moral Construct and Blame-Related Distress

Moral constructs in MD are described as having a moral obligation to act, followed by moral consequences to inaction resulting in associated symptoms [10-14] . These moral constructs were used to develop Hypothesis 1 examining the relationship between B-RD and MD. Table 2 (expanded in Supplemental digital content 5) demonstrates the relationship between this hypothesis, the specific moral construct measured, and related survey questions. In those who experienced blame, 80% ($n = 62$) reported a moral obligation and 78% ($n = 61$) had a moral consequence. Symptoms associated with MD occurred in 86% ($n = 67$) of the respondents. A majority, 68% ($n = 54$) met all 3 criteria signaling that B-RD often, but not always contained a moral construct. Figure 3 demonstrates the distribution of self-reported symptoms.

Testing of the hypotheses provided further demonstration of the relationship between what is known about MD and B-RD. Table 1 (expanded version found in Supplemental Digital content #4) demonstrates the results of this testing. Even though originally tested to confirm construct validity, these statements were not supported. The fact that duration of B-RD was not associated with resources provided or used, incidence were not related to length of time in service, and intent to leave position was not related to higher levels of distress begins to discriminate B-RD from MD.

Novel Questions about Blame-Related Distress

Three novel exploratory questions were asked that were constructed by a staff nurse involved in the construct validity testing who had noted that these issues were not covered by other research questions. These exploratory questions do not contribute to understand the relationship between blame and MD, but instead begin to explore more deeply the distress specifically related to blame (Table 3).

Guilt or Self-Blame

During initial construction of the survey, self-induced blame or guilt was not explored because the focus of the study was to explore the similarities between MD and B-RD. Even though self-blame is reported as a consequence of MD [15], a relational construct needs to be present for MD to exist [12, 13]. Moral distress is characterized by experiences shared between 2 or more people and being constrained from taking action [12-14]. However, during the oncology conferences, 3 nurses asked to express their thoughts about guilt and a new question was constructed

for use with the next group of participants who were ICU nurses. In 62% (*n* = 15) of ICU participants that had experienced B-RD, the blame from others caused them to blame themselves in the form of guilt.

Limitations

Since ARCs were used, questions that could have been answered in a "select all that apply format" had to be broken down to individual questions and did increase research burden. Additional data should be collected among different nursing specialties and professionals to get a broader understanding of B-RD and test the findings. Since these data were collected from an acute care setting, it is not generalizable to all nursing specialties or settings. However, the results were the same in both groups suggesting that B-RD may present similarly in different roles and settings. The questions were constructed to explore only blame induced upon the participant by someone outside of self or self-blame caused by being blamed by others. It is not known how often self-blame or guilt occurs in the absence of being blamed by others which is a topic for further study.

Another limitation is that the participants may have learned about moral distress, burnout, and compassion fatigue immediately prior to the survey. Given the short time to process the information, their answers may reflect an inaccurate representation of the deeper meaning of these constructs. Further, self-disclosing depression, compassion fatigue, burnout, and anxiety is less reliable than assessment by a trained professional.

The survey was designed to measure current intensity of MD but not the MD level at the time the event occurred. Therefore, the B-RD intensity could not be compared to the MD intensity as originally planned. This was a flaw that none of the content experts identified prior to executing the survey.

Implications for Practice

Figure 4 demonstrates proposed relationships between blame and MD, burnout, compassion fatigue, and 2nd victim as constructed from the literature review plus the results of this study. Although this study was not performed

utilizing a grounded theory approach, we present the following arguments for the proposed relationships in the conceptual model. Whether these proposed relationships hold true warrant further study.

There was significant overlap between the antecedents, symptoms, and consequences of distress caused by blame and MD but they were not found to be equal (Table 1; Hypothesis #1). Most participants with B-RD also reported that there was a moral underpinning to the situation: 85% ($n = 61$) felt that they took action according to profession and personal values, moral, or ethical beliefs; 72% (n=49) felt the action was morally required; and 59% (n= 41) that the blame violated what they felt were core duties or obligations.

Because participants were only asked about symptoms that had been reported in the MD literature, there were several participants who reported distress but none of these symptoms were explored in the survey. There are other possible symptoms of B-RD.

As in MD [11, 16], BR-D may result in residue or consequences that linger long after the event. In this study, 35% ($n = 21$) of participants had B-RD that was still present on the day of the program (median = $1 - 5$ years after the event). Matching the previously described 2nd victim syndrome, we found that talking to colleagues was the most frequently reported helpful resource [5, 6, 17] suggesting that programs focused on the use of colleagues to help ameliorate the impact of blame may be successful.

Nurses in this study reported that blame can be relational or self-induced. Moral distress is a relational construct requiring interaction between 2 people [12]. One or more people or the organization prevent someone from doing what they feel is right [13, 14]. Three participants in the oncology group and 62.5% ($n = 15$) of the ICU group reported self-blame. The ICU-specific question asked if being blamed by others caused guilt. Pure self-induced blame, separate from the guilt imposed after being blamed by others, could be the topic of a future study. The fact that self-induced blame may occur without relationship to others is a difference that could, if found, further distinguish blame from MD.

Burnout may be a consequence of MD or lateral violence. Compassion fatigue is a subset of burnout [18-20]. We found in this study that in those who were blamed for a negative patient outcome (18%; $n = 13$) also self-reported compassion fatigue and 27% ($n = 20$) reported burnout. Therefore, there is some overlap.

Second victim syndrome can occur as a result of MD, compassion fatigue, burnout, or lateral violence [5, 6, 17]. In this study, the symptoms reported with 2nd victim syndrome, also symptoms exhibited in MD, were present in those with B-RD. A discrete question was not asked about 2nd victim syndrome, but because so many participants with BR-D also reported MD, compassion fatigue or burnout and related symptoms, it is clear that there is overlap between these constructs. As a result it is proposed, though not previously disclosed in the literature, that B-RD is 1 possible contributing factor to the development of 2nd victim syndrome and warrants further study.

In this study, the source of blame was explored and 37% ($n = 28$) reported that blame was received from staff nurses. The majority of participants were staff nurses (72%; $n = 52$). Not all blame occurred when someone made an intentional error. If the error was unintended and not intentional or willful acts of malice, the blame could be considered lateral violence. It is proposed that most blame is not justified because most adverse outcomes do not result from willful acts. Researchers did not explore whether the blame was received with or without justification; however, following this logic, the data suggests that some of this blame was inflicted as lateral violence. Reflecting on this, we propose that the BR-D could be a result of lateral violence (when blame occurs following an unintentional adverse event), but lateral violence is not required to have blame. Exploring further the relationship between lateral violence and blame is indicated.

Conclusion

Blame-related distress is prevalent among ICU and oncology staff. This distress can come from many sources. The blame frequently results in moral consequences and symptoms commonly associated with MD. There is an organizational impact to perceived blame for a negative patient outcome in terms of staff morale, turnover and retention. Blame may be relational or superimposed with guilt when blamed by others. Participants reported that most organizational resources provided to promote a healthy work environment were not used, not helpful or they were unaware that the resources existed (e.g: leadership intervention, human resources intervention, psychological

counseling). Co-workers and friends were found to be most helpful in dealing with blame. Therefore, programs that encourage staff to help each other through difficult situations may be more effective than leaders handling the situation independently. Wellness programs, behavior standards and training programs to promote a healthy work environment could include content on B-RD and the consequences of blame. Future research is needed to identify useful strategies to prevent blame and minimize the impact on healthcare workers. This study warrants replication in other disciplines and specialty areas of practice. The B-RD survey warrants conversion to e-survey format and further validation in larger populations.

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