As we learn more about accidents, the role of the system in which the accident takes place and the imperfect beings that humans are, we are realizing that blaming the person who made the mistake is the biggest mistake. Many factors create the accident. Simplifying to the point of blaming limits learning and the ability to prevent similar occurrences in the future.

Some cultures nurture blaming until it becomes an integral part of the workings of the inner core of the organization. Errors and mishaps are assumed to be the fault of one person and the investigation of an issue will proceed with that paradigm until the culprit is found. As Bill Doyle, a pioneer loss prevention engineer said, “For every complex problem, there is at least one solution that is simple, plausible...and wrong” (Kletz, 2001). Kletz (2001) notes that most simplistic solutions to problems depend on identifying a devil. He cites unscrupulous managers who want a quick solution to a safety problem as an example of the drive to name the devil. Unfortunately, we have heard too many organizations scapegoat and blame a person, who is often the last and most junior person in the chain, as the cause of a mishap (Kletz, 2001). However, Kletz (2001) and many other accident investigators find that mishaps are rarely the result of the fault of a single person. Many people in the chain of events had the opportunity to prevent the error but were unable to do so.

In these cultures of blame, rarely do the real facts about the problem emerge because people are reluctant to disclose what happened for fear of blame or punishment. When the facts are withheld, the safety of the organization is undermined because the critical information necessary to prevent a similar problem is not available and multiple mistakes of a similar nature will happen (Weick & Sutcliffe, 2007). In health care, this is serious because of the potential harm and/or death that can be repeated over and over again.

**Components of the Blame Culture**

Whittingham (2003) describes the blame culture as one that “over-emphasizes individual blame for human error at the expense of correcting defective systems” (p. 225). He notes these cultures are secretive, errors are not acknowledged, and staff will attempt to conceal their errors because of the possibility of punitive action. The importance of individuals is not recognized; management decisions are made in isolation. Consequently, there is a serious lack of motivation, a climate of stress and fear, and high staff turnover. As a result, most of the work is performed by inexperienced people with the probability of errors being very high. A very serious outcome of this culture is that valuable information that would make the organization safer is not made available, and there will be more accidents of a similar nature.

Often, the characteristics of the blame culture are very subtle and what appears to be valuable work is actually a subtle sign of the blame game. Ebright and Rapala (2003) state that if the conclusion of human error is made the culprit, topics such as work complexity will not be examined and the learning to prevent future problems will be absent. Also, defaulting to re-education as an intervention implies that the person who made the error only needed education to prevent the problem. In reality, error prevention is much more complicated than re-education.

Organizational culture can be created by leaders of individual staff or a combination of both. These cul-
tures don’t just happen. They are willfully created by the actions of specific people who act from a variety of motivations. Just as these blaming cultures have been created, so can the opposite kind of culture be created.

**Moving from a Blame Culture to an Open, Learning Culture**

Whittingham (2003) describes an open culture as one that is open to the possibility of error and creates a climate in which errors can be discussed freely and the underlying causes are investigated and corrected quickly. These characteristics are often apparent when surveys of the staff’s perception of safety or engagement are completed in organizations. These surveys provide an excellent base from which the leader can focus to change the culture.

A characteristic of a Highly Reliable Organization, in which the possibility of error is minimized, is preoccupation with failure (Weick & Sutcliffe, 2007). This can only happen in an open culture. Reporting of errors is supported positively, everyone is encouraged to participate in discussions of near misses, and staff know about human factors that can lead to errors (fatigue, lapses, and inadequate training) and what to do prevent these from causing accidents. Whittingham (2003) also notes that a confidential reporting system is necessary to move from the blame to the open culture. These are more commonly known as “hot lines” or corporate compliance lines and serve as a nice interim vehicle to move from blame to open reporting.

**Change the Language**

Kletz (2001) tells us we must change our language to change the culture of blame. In a blame culture, we look for the single cause, perpetrator, or root cause of the problem. Kletz (2001) recommends that we stop using the language of “cause” and instead use the proactive language of “How can we prevent this in the future?” Kletz (2001) believes that invoking the word “cause” demotes an air of finality that discourages investigation. But if we use words like, “What could we do differently to prevent another accident?” we will change the culture to one of openness and prevention quickly.

Dekker (2006) notes that using the word “failure” indicates that you are handing down a judgment from outside the situation. He believes that when people respond with indignation, or appear angry or upset, they seriously limit the opportunity to understand the situation from the other person’s perspective and a great opportunity for learning does not become a reality.

**Lessons for Leaders**

Leaders create the cultures by allowing certain behaviors to grow and thrive. If people blame each other in a work group rather than ask how a situation can be better handled in the future, the leader has not set the behavioral standards that will eliminate blame and create a culture of learning and proactive prevention of problems. Leaders must change the language to a proactive, future preventative state rather than focusing on the past and looking for single causes of events. As leaders model the way and use proactive, future language, so will the staff. However, we must hurry. Many nurses have left their positions because they have chosen not to work in a culture of blame. Eliminating all forms of blame is essential for excellence in patient care outcomes and loyalty of staff. It begins with a proactive approach that eliminates the blame and instead proactively asks what can be done differently in the future.$

**REFERENCES**


