Beyond blame: cultural barriers to medical incident reporting

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Abstract

The paper explores the attitudes of medical physicians towards adverse incident reporting in health care, with particular focus on the inhibiting factors or barriers to participation. It is recognised that there are major barriers to medical reporting, especially the 'culture of blame' these is a 'culture of blame'. There are, however, few detailed qualitative accounts of medical culture as it relates to incident reporting. Drawing on a two-year qualitative case study, this paper presents data gathered from 28 semi-structured interviews with specialist physicians. The findings suggest that blame certainly inhibits medical reporting, but other cultural issues were also significant. It was commonly accepted by doctors that errors are an 'inevitable' and potentially unmanageable feature of medical work and incident reporting was therefore 'pointless'. It was also found that reporting was discouraged by an anti-bureaucratic sentiment and rejection of excessive administrative duties. Doctors were also apprehensive about the increased potential for managers and non-physicians to engage in the regulation of medical quality through the use of incident data. The paper argues that the promotion of incident reporting must engage with more than the ubiquitous 'culture of blame' and instead address the 'culture of medicine', especially as it relates to the collegial and professional control of quality.

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Introduction

International research has shown that errors in the delivery of health care are a major threat to patient safety (Brennan and Leape 1991, Wilson et al. 1995, Vincent et al. 2001) In the National Health Service (NHS) of England and Wales it has been reported that mistakes or 'adverse events' in the delivery of health care are experienced in around 10% of inpatient admissions (Department of Health 2000, Vincent et al. 2001). It has been calculated that the human cost of these mistakes could be more that 40'000 lives a year with a financial cost to the service of over £2billion in additional care (Department of Health 2000).

A 'patient safety' agenda is now well established in countries such as Australia, the US and the UK (Department of Health 2000, Institute of Medicine 1999, Wolff and Bourke 2000). In the NHS, health policies have adopted the principles and practices of error management that have been successfully utilised in other industries, such as aviation or nuclear energy (Department of Health 2000, 2001; Reason and Hobbs 2003). Here the theories of cognitive and social psychology, ergonomics and 'human factors' have combined to produce a new orthodoxy of error management (Reason 1997). From this perspective threats to safety are elaborated along two dimensions. The first recognises the individual component where cognitive lapses or aberrations lead to *active* errors. The second emphasises the *latent* factors that enable or exacerbate human error within organisational systems (Reason 1997). Human behaviour is regarded as inherently error-

prone but importantly these errors are facilitated or amplified by actions, decisions, and plans made elsewhere, or 'upstream' within the system.

The management of errors requires an acceptance of error with consideration given to the relationship between individual human behaviour and the factors that influence this behaviour (Reason and Hobbs 2003). In practice, error management requires that organisations learn from their threats to safety, identify the underlying causes, and seek out opportunities for change. This commonly involves the introduction of designated incident reporting systems that enable front-line staff to communicate their safety concerns and experiences of error to those responsible for safety and quality. These incident reports then furnish organisations with the necessary information and capacity to make proactive and remedial changes.

It is recognised, however, that there are considerable barriers to the successful implementation of error management and incident reporting systems (Barach and Small 2000). In the safety management literature, significance is given to the cultural barriers and the need to create a 'safety culture' (Helmreich and Merritt 2001, Reason 1997, Reason and Hobbs 2003). Helmreich and Merritt (2001) have shown how safety management must navigate national, organisational and professional cultures where issues as diverse as individual responsibility, gender divisions, teamwork, competence levels, transparency and punishment interact to shape cultural attitudes towards safety. Considerable significance is given to the fear of blame or the 'culture of blame' that inhibits participation in incident reporting. It is argued that people are disinclined to be

open an honest about their experiences of error because of the deep-seated assumption that they will be found at fault and held individually responsible or punished for the event. As such, the fear of blame and retribution are seen as major cultural barriers to incident reporting. For Reason (1997) this culture of blame arises, in the widest sense, from the primacy accorded to individual autonomy in Western culture and as such individual responsibility for mistake or blame is apportioned when 'things go wrong'. As such there is an assumption that openness and transparency, including forms of incident reporting, make possible the allocation of individual responsibility and therefore serve to distribute blame and possibly secure some form of retribution. Reason has argued that for error management to make a meaningful contribution to safety it is necessary to break free from the "blame cycle" and promote a "reporting culture". This he argues can be achieved through practical measures, such as the de-identification of reporters, protecting reporters and whistle-blowers from unwarranted reprisals, and providing meaningful feedback that highlights the purpose of error management. More recently the notion of a 'safety culture' has been elaborated to suggest that safety is driven by a "learning culture" that actively seeks out previous experiences of error in an effort to ensure they do not happen again. This is underpinned by a 'reporting culture' where staff routinely document and communicate their experiences of error to enable this learning. Accordingly, it is suggested that high levels of reporting are secured through the creation of a 'just culture' that recognising human fallibility but importantly establishes clear expectations of responsibility and does not unfairly or routinely blame or punish those who make mistakes.

The ‘patient safety’ agenda in the NHS has embraced the principles of human factors and practices of error management (Department of Health 2000, 2001; NPSA 2001, 2003). The National Reporting and Learning System (NRLA) is currently being implemented across the health service to enable front-line staff to record and report their experiences of error, and it is anticipated that through the collection of this information error producing factors can be identified and managed. It is recognised, however, that there are considerable barriers to staff participation in incident reporting and significant levels of ‘under-reporting’, especially for medical physicians (Barach and Small 2000, Coles et al 2001, Vincent et al 1999). Significant factors included individual uncertainties about the purpose of reporting, the practical design of incident forms, systems of organisational communication and feedback and apprehension about the unjust consequences of reporting (Coles et 2001, Vincent et al 1999).

Significant among the barriers to incident reporting in health care is the ‘culture of blame’ that inhibits reporting because of the expectation that those found at fault will be individually held accountable or responsible (Coles et al 2001, Department of Health 2000, Vincent et al 1999). Although this is widely recognised in the error management literature, it is important to put this within the context of health care cultures, especially medical professional cultures. Helmreich and Merritt’s (1998) analysis of work and safety cultures in aviation and medicine makes the point that professional groups are characterised by high levels of self-esteem, invulnerability and denial. As such reporting is discouraged because of a fear that they could reveal specific flaws in professional competence and individual ability, and provide a basis for professional sanctions or

punishment. In addition, Lawton and Parker's (2002) study of incident reporting found that reporting is constrained by the specific occupational hierarchies of health care where professionals are typically reluctant to report their experiences of error, rule violation or poor performance to senior colleagues because of the cultural taboos associated with whistle-blowing and the assumption that it could inhibit career development.

These studies of blame and incident reporting give an indication of other more deep-seated and long-standing cultural dimensions of health care that have an important bearing on the implementation of incident reporting. Specifically, other studies have shown how the medical profession is characterised by a 'closed culture' that inhibits openness (Department of Health 2000, Kennedy 2001). Rosenthal's (1995, 1999) study of 'problem doctors' found that physicians generally accepted mistakes as a necessary feature of their work. It was expected, however, that any issues of competence or wrong-doing should be addressed through 'in-house' and 'collegial' practices that served to maintain the exclusivity of medical knowledge whilst simultaneously limiting exposure to non-professional groups. Allsop and Mulcahy's (1998) study of patient complaints found that physicians regarded complaints as a challenge to their expertise and technical competence, and therefore constituted a threat to their professional identity. However, it was also found that the shared feelings of vulnerability and the loss of status serve to promote a collective understanding and attitude towards complaints that maintains professional control and identity in the face of these external or non-professional challenges. These works highlight the significance of collegiality in medical culture, and accordingly illustrate the importance of internal or self regulation to medical

professionalism. It is well-established how the regulatory character of medicine, including both formal and informal practices of occupational control, have served to ensure professional monopoly in the evaluation of medical work and exclude the participation of non-professional groups in the management of technical performance (Allsop and Mulcahy 1996, Friedson 1970, Lupton 1998, Rosenthal 1995). This broader theoretical context of professional regulation and collegiality is therefore central to the issue of medical reporting.

Drawing from this theoretical background and with specific focus on the medical profession, this paper aims to explore the cultural attitudes and barriers to incident reporting in the NHS. Importantly, the success of incident reporting is to a large extent premised on the creation a 'just culture' that counters the fear of blame, encourages openness and underpins a 'culture of reporting' (Department of Health 2001, NPSA 2003). Initially, this work suggests that the notion and significance of 'blame' presented in policy is somewhat vague, whilst there is little current empirical data to show how the 'culture of blame' influences medical attitudes towards incident reporting. Secondly, although the fear of blame may indeed be a substantial barrier to reporting, there is little consideration for other cultural factors that could also influence participation in incident reporting. This paper therefore aims to provide an empirical account of the medical attitudes towards incident reporting, and with consideration given to the broader socio-cultural theories of medical professionalism (e.g. Freidson 1970, Rosenthal 1995), it aims to move beyond the ubiquitous concern with a 'blame culture' and engage the other deep-seated cultural features of medical professionalism.

Methods

The results reported here were gathered between 2001 and 2003 from a larger qualitative study of clinical risk management and incident reporting. The setting for the study was a single medium-sized NHS District General Hospital in the English Midlands. The organisational site was selected because it was found to be typical of other acute hospitals in the NHS that were currently coming to terms with patient safety policies.

Interviews constituted the predominant method of data collection. In total 42 interviews were conducted with medical and managerial staff from across the hospital. Initially, 12 respondents were 'theoretically sampled' (Strauss and Corbin 1999) on the basis of their participation in the management and administration of quality improvement, clinical risks, and mistakes in the hospital. This included 9 senior managers (one of which was interviewed twice) and 3 senior medical representatives. A second sample of 29 interviews was conducted with staff working in five specialist departments in the hospital, including Anaesthesia, Acute Medicine, Obstetrics, Rehabilitation and Surgery. This representative sample comprised 25 specialist consultant-grade physicians (5 from each department) and 4 local risk managers. Importantly, the data used in this paper is drawn from the 28 interviews with medical staff (3 senior medical representatives and 25 specialist physicians).

The interviews followed a broad thematic guide that was concerned with gathering occupational narratives, accounts of recent developments and changes in the management of safety and risks, descriptive accounts of hospital and localised incident reporting systems, attitudes and practices towards incident reporting and risk management, and issues about the control and management of medical performance. Each interview was prefaced by a review of the study's aims and all respondents were made aware of the ethical considerations before acquiring their consent. The interviews lasted between 40 minutes and 2 hours with an average of approximately an hour.

It is recognised that qualitative interviews rarely provide an unproblematic source of data. Furthermore, given that 'medical mistakes' are a high-profile and sensitive subject seemingly shrouded in secrecy and associated with a 'blame culture' (Department of Health 2000) it is especially necessary to consider the implications for validity and reliability in this study. With regards to the validity of the interview data, it is recognised that participants could have been particularly apprehensive about discussing their mistakes with a non-peer and an 'outsider'. It could be speculated that the interview responses were implicitly concerned with portraying an 'image' of competence and not providing information that could be used to blame or negatively characterise participants. Specifically, the full and honest participation of physicians in the interviews could have been influenced by the same cultural factors or barriers that inhibit medical reporting. With regards to the reliability of the data it is necessary to consider the limitations of drawing substantial conclusions about medical culture based on only 28 interviews. Given the prevalence of quantitative data in this area (e.g Parker and Lawton 2002),

however, it is believed possible to meaningfully contextualise this data within the existing theoretical and empirical literature.

All interviews were electronically recorded and transcribed verbatim into a word processing package. The data was then imported into the qualitative data analysis computer package *Atlas ti* for the purposes of coding and content analysis. Initially, this involved manually examining the interview data to identify descriptions, cases, occurrences and attitudes in the talk of respondents. A pre-determined coding frame was not developed in advance of the study, but throughout the indexing and coding process implicit consideration was given to theoretical and policy issues, as well as to emergent and unanticipated and 'grounded' themes within the data. Following the comparative approach outlined by Strauss and Corbin (ref), these categories and codes were systematically compared and contrasted, with reference to the primary data, to verify the views of individual respondents and to identify contradictions and conceptual relationships within the data. This coding process contributed to the development of empirically driven themes that are used to characterise the attitudes and values of doctors. These are explored in the following section with example quotations to illustrate the findings and interpretation given.

Results: cultural barriers to reporting

The fear of blame and the fear of reporting

All doctors involved in the research made reference to the "blame thing" or a "blame culture" when expressing their apprehensions about incident reporting. It was evident from the way doctors discussed blame that it was perceived to involve the unfair or inappropriate allocation of responsibility for poor performance or outcomes, and possibly the unwarranted recourse to reprisals and punishment. It was also evident that there were different sources of blame that also made doctors apprehensive about being open or reporting. The most commonly cited source of blame was associated with the "the public" and "the press", and through association "the Trust", which strive to make doctors culpable for care that does not meet particular standards or expectations. This *external* blame was compounded by the increased presence of litigation in health care, and like the findings of Allsop and Mulcahy (1998) this seemed to question professional competence and promote feelings of vulnerability. Another source of blame stemmed from the occupational or *internal* aspects of medical practice where it was felt that increased openness about individual competence could lead to the questioning of professional practice and lead to poor references, reprimands from a senior colleague or could tarnish the reputation of the consultant. This internal blame appears to reinforce and develop the problem of occupational hierarchies identified by Lawton and Parker (2002).

> "it's partly culture, its fear of litigation…and its partly the old culture of preferment in terms of jobs and things, and how consultants and seniors could blot your career" (Respondent 6).

The unjust and inappropriate allocation of blame, whether from inside or outside the profession, appeared to negatively influence the attitudes of physicians about incident reporting and discourage participation. The majority of doctors suggested that their apprehensions about blame discouraged reporting because it provided the Trust or colleagues with information about individual weaknesses that could be used to "point the finger at clinicians who are trying to do their best" (Respondent 30).

> "it seems just like another witch hunt against clinical staff on the front line who are doing their best" (Respondent 20).

> "And there's a culture of not wanting to fill these things in and wondering what sort of blame is going to come your way" (Respondent 5).

More than half of the participants gave anecdotal accounts of colleagues who had been "reprimanded" or "investigated" following the submission of a report. Although specific details were rarely given, there were some common 'stories' such as the junior doctor who was suspended and the doctor who used as a scapegoat following a drug-error. These 'folk tales' appear to symbolise and perpetuate the feelings of unease and the fear of blame, associated with making incident reports and helped to justify not reporting. One

major anxiety was that incident reports would be used by managers to store information about bad practice that could be used at a later date in the event of medico-legal disputes.

Despite the efforts of policy-makers, hospital managers and professional leaders to promote a "just culture" and encourage medical reporting, the interview data indicated that doctors remained sceptical and apprehensive about the purpose and application of incident data. As such it was apparent that the idea of no blame or fair blame were regarded as rhetorical and possibly even managerial strategies and therefore they had failed to make any substantial impact on the doctors. This reference to managerial scrutiny is further developed below.

> "Although that culture has changed I still think there are a lot of people who would be reluctant to [report] if they could get away with it because there would still be a fear of retribution" (Respondent 27).

Alternatively, a small group of participants, mainly senior medical representatives and clinical directors, were more aware and supportive of recent developments in 'patient safety'. For these doctors incident reporting was certainly regarded as a practical mechanism for encouraging quality or service improvement, but fundamentally this was premised on the capacity for reporting to shift the responsibility and blame for poor quality care further up the organisational hierarchy. Specifically, it was suggested that incident reports could be used to reinforce claims for organisational change by demonstrating the need for more resources, equipment, or staff. Selectively embracing

some of the principles of human factors, these doctors identified the source of error within the wider organisation and management of service and not in their own clinical work. In consequence, incident reporting not only served as a tool for legitimising the request for change, but also allocated the responsibility for poor quality away from medical practice. It could be argued therefore that rather than exhibiting a desire for a "just culture" or "no blame", these doctors were attempting to "shift the blame" through the use of an incident report.

For all the doctors involved in the study the fear and allocation of 'blame' certainly influenced their attitudes towards openness and their participation in incident reporting. Generally it was found that reporting could serve to present opportunities for both medical and non-medical groups to scrutinise performance and damage professional reputations and perceptions of competence. Only when the blame for poor performance could be allocated elsewhere did the small group of senior doctors recognise the value of reporting. It is worth considering that the prominence of 'blame' in the talk of doctors may reflect the growing significance of the subject in recent policies. The notion of a blame culture may therefore provide doctors with an obvious and legitimate justification for not reporting when in actual fact other cultural issues could be interpreted as potentially more influential in shaping medical attitudes towards and participation in incident reporting.

The inevitability of error and the purpose of reporting

It has been demonstrated elsewhere how the inherent and 'permanent' uncertainty of medicine has necessitated that doctors accept the risks of error in their work, to the extent that it has become a defining characteristic of medical culture and practice (Fox 1975, Rosenthal 1995, 1999). Moreover, the ambiguities, variability and "gaps" of medical work have been central to the development of collegial practices for the control of risk and error (Bosk 1979, Fox 1975, Paget 2004, Rosenthal 1995). Similarly, this research revealed that far from working on the premise of "perfection" (Leape 1999), doctors regarded errors as an inevitable and sometimes beneficial dimension of their work. It was found that the majority of physicians believed all human activity was prone to error: with a small group of doctors directly quoting Alexander Pope's dictum "to err is human" (Pope 1709).

> "Human error is always going to occur" (Respondent 15)

The inherent uncertainty of medicine was often expressed in the interviews by respondents referring to their work as "less of a science and more of an art" (Respondent 12) or emphasising the "trial and error" character of medical practice (Respondent 26). It appeared that the cultural acceptance of uncertainty and complexity necessitated that doctors also accept the inevitability of mistake in their work. Not only was a degree of error regarded as acceptable, but reinforcing the work of Bosk (1979) it was claimed to be beneficial for the learning processes of trainee and junior doctors. Furthermore, errors

were widely accepted as an inevitable consequence of working within a complex organisation such as the NHS, where the work of the individual clinicians is dependant upon the activities of many other people and organisational processes.

The perceived inevitability of error and its acceptance in medical culture are extremely significant for understanding medical attitudes towards in incident reporting. In one regard it could be suggested that this feature of medical culture provides the basis for a shared and collective rationale to bolster individual self-esteem and safeguard against feelings of incompetence, on the grounds that errors will always happen regardless of ability, and in consequence this may help to explain and mitigate errors 'after the fact' or *ex post facto*. More significantly, however, it could also be the case that the inevitability of error leads to more than their acceptance, but also to their 'normalisation'. This is where some common mistakes are regarded as routine and normal within the context of medical work, and in consequence these events are not perceived as problematic or worth reporting. For example, the distinction between error and "complication" or "side-effect" was often vague in the talk of doctors and served to question the relevance of reporting.

In addition, medical participation in incident reporting was more explicitly questioned in terms of its capacity to actually tackle the 'trial and error' nature of medical work and make meaningful service improvements. Given that errors were regarded as inevitable doctors often regarded reporting as 'pointless' or a 'waste of time' on the grounds that these mistakes could never be fully eradicated and instead they should just be accepted. In consequence participants could see little purpose for incident reporting.

> "What good does it do? It's not like it could ever make us error-free." (Respondent 5)

> "The best intentioned doctor will make mistakes, there but for the Grace of God… but you don't report all these, what would be the point" (Respondent 27).

> "What am I going to get out of it, or what is the patient going to get out of it, or what are my colleagues going to get out of it, and if they don't see anything valuable or a valuable learning lesson then people don't do it [report]" (Respondent 26).

As these quotes demonstrate, the doctors remained sceptical about how incident reporting could contribute to service improvement given the uncertainty of medicine and inevitability of error. Accordingly, the majority of respondents were perplexed about the "end point" or ultimate purpose of the scheme. On the one hand this may demonstrate a lack of awareness about how reporting can contribute to service quality. On the other hand it may be reflective of a deeper division between medical and managerial approaches to quality improvement. The interview data appeared to indicate that doctors did not value incident reporting because it failed to recognise that mistakes are an inevitable feature of medical practices and, importantly, they are based 'within' the uncertainties of medical knowledge and practice. In consequence, the doctors tended to

regard incident reporting as a managerial exercise and questioned its contribution to service quality.

> "So I think some of these things get labelled with 'it's just collecting data for the sake of it', because somebody in management has to tick boxes and send off to the Department of Health" (Respondent 10).

> "It struck me that the work of risk management is about guards around emergency exits on the stairs…but we haven't seen to the everyday events that are happening. So I don't see doctors filling those in" (Respondent 13).

The doctors therefore explicitly questioned the purpose of incident reporting and its contribution to service improvement. As suggested above in the discussion of 'blame', doctors were indeed supportive of reporting when it could be used to "flag up topical issues" or persuade managers to release additional resources. In this regard these quotes suggest that doctors often question how 'managers' prioritise the allocation of resources and the management of risks. It may be the case therefore that whilst this remains the case doctor will also remain sceptical about the contribution that incident reporting could have to their work. Conversely, for those doctors involved in the Confidential Enquiries, such as Peri-operative Deaths or Maternal Deaths, this professional-based reporting was more valued because it was based 'within' medical practices, and therefore implicitly accommodated the uncertainties of medicine and was perceived as making a more meaningful contribution to service quality.

Rejection of bureaucracy and managerial scrutiny

A prominent theme that characterised the views of doctors and emerged from the issues raised above was a strong revulsion of what was often termed "bureaucracy", "red tape", "admin" and "management". The difficult relationship between medicine and management is well-documented elsewhere and shows how the changes in health service organisation and management have often challenged medical status and authority (e.g. Strong and Robinson 1991, Harrison and Pollitt 1995, Harrison 2002). This research revealed how, possibly as a reflection of these changes, doctors seemed to have a deep-seated loathing of rule-based and managerial practices that were diametrically opposed to the ideals of individualism, discretion and autonomy that characterise medical practice and culture (Freidson 1970, Lupton 1999). This aspect of medical culture had a significant impact on the participation of doctors within risk management systems and incident reporting.

When the doctors were asked about their experiences and involvement in incident reporting their responses referred to the excessive time required for form filling that could be better spent with patients and the menial nature of paperwork that was somehow beneath medical expertise.

> "I think the culture is never going to be there for a mass of form filling" (Respondent 9).

> "Doctors are the worst people to follow mandatory rules, if there is anything mandatory doctors will think of a way for somebody else to do it" (Respondent 14).

> "Well reporting, it's a big brother thing." (Respondent 5)

The doctors were particularly concerned that the growing number of bureaucratic hospital procedures would reduce their capacity for "real" medical work. This may demonstrate the importance of 'the patient' and 'health improvement' to medical culture, where administrative and 'managerial' procedures are avoided and shunned because they are not seen as directly contributing to medical work or patient care. On the one hand this viewpoint, however, could have been offered by the participants as a reasonable explanation for delegating or avoiding administrative tasks. On the other hand it also demonstrates the clear scepticism that doctors have in the capacity for managers to contribute to medical work. Furthermore, it was also found that there was a deep-seated assumption that these activities were particularly 'un-medical' and 'un-professional'. Specifically, the doctors were highly critical of the ability for non-medical groups to sufficiently understand and interpret medical errors because of the clear lack of expertise. It was suggested by over half of the participants that managers with no front-line clinical

experience would struggle to understand the ‘realities’ of care provision and would evaluate incidents “out of context” and without legitimacy.

> “with clinical incidents managers don't really know much, they may clutter things up with all sorts of policies and regulations and so on, but they don't directly contribute to dealing with the incidents” (Respondent 5)

> “I think the worry is that managers don’t actually understand medicine. I see things differently, I deal with different things, but management deal with other things, its all about quality but they can’t understand what I do clinically” (Respondent 15)

The anti-bureaucratic sentiment of medical culture may also be demonstrative of the desire to undermine and curb the enhanced managerial scrutiny of medical practice, especially the evident potential for incident reporting to directly engage with medical quality. When this theme was pursued with the respondents it was found that doctors not only feared the potential blame that could be brought about by revealing mistakes, but more fundamentally there was anxiety about the new opportunities that incident reporting would provide for none medical groups to survey and evaluate practice. For some this was expressed as a direct challenge to the regulatory character of medicine, whilst for others it was felt that medical work would soon become the target of performance management. Given the significance of this anti-managerial and bureaucratic feeling, it was unsurprising to find there was little support for the expansion of incident reporting,

especially since it may reinforce any concerns or fears about blame, as well as introducing new non-professional regulatory practices.

> "I see it more and more as hemming in and putting the clinicians under scrutiny" (Respondent 12).

> "I think there is a potential problem with a them and us situation where there are people working hard in a clinical situation and some manager sitting in an office somewhere is going to look at the incident forms and come down on us in a judgemental way" (Respondent 25).

> "My personal view is that if it's done in a controlling manner then you may get results but how valid are they?" (Respondent 2)

Divergent occupational responsibilities and expertise

In the light of the above findings one of the most interesting themes in the interviews with doctors was the sentiment that incident reporting was designed and operated primarily for other occupational groups that were more suited to bureaucratic procedures, especially 'nursing'. Doctors often claimed that incident reporting grew out of the nursing profession because its culture was familiar with 'form filling' and 'paper work' and more amenable to managerial control.

> "The nurses tend to fill in absolutely anything, that sounds a bit unfair…but there is also this element of 'I'm filling this in to cover myself and I have passed it on'…. You can see the strengths in both systems, while one system under-reports but avoids bureaucracy the other one is obviously very safe but creates a mass of writing and work" (Respondent 26).

> "Doctors regard those as nurse-led and about falls in the hospital" (Respondent 13).

The way in which doctors talked about incident reporting and nursing was often off-hand and demeaning, but at a cultural level it may be the case that for doctors incident reporting is associated with divergent forms of professionalism and quality improvement. The way doctors talked about their own work in relation to nursing tended to emphasise the importance of their individual expertise and discretion, while the work of nurses was regarded as more rule-based, process driven and procedural. This may demonstrate an underlying assumption that medical practice is characterised by a special kind of expertise, experience and reflective practice that is different from nursing. In consequence, reporting is not regarded as an appropriate tool to engage with medical quality, but because nursing lacks this special quality, it is believed that reporting is an appropriate device for enhancing the quality of nursing care. The findings suggest that the longstanding association of reporting with nursing and the perceived lack of relevance of

reporting to medicine further discourages doctors from using incident reporting as a mechanism of quality improvement.

Discussion

The interviews with physicians revealed several significant themes that characterised the way in which they understood their work and their participation in incident reporting. These reveal interesting features of medical culture in general and identify important cultural barriers to incident reporting. The fear of blame from both peers and non-peers was certainly found to discourage medical reporting on the basis that reporting could damage professional reputations or led to unjustified reprisals. On a reflexive note, it could be argued that prominence of the 'blame culture' as a justification for not reporting was found precisely because of its prominence in policy and managerial discourse and it therefore provides a widely recognised reason for not reporting. However, the research demonstrated the need to look beyond the ubiquitous focus on 'blame' and consider other cultural facets of medicine. In particular, it was found that the perceived inevitability of error provides doctors with a justification for not reporting on the basis that it could never substantially prevent these mistakes from occurring because they are an implicit feature of complex medical work. Moreover, the acceptance of error goes beyond questioning the purpose of reporting and leads to the normalisation of error to the extent that they can be discounted as problematic issues that require reporting. The doctors also expressed anxiety about the proliferation of bureaucratic techniques in their work that not only take

them away from 'real' medical work, but more insidiously represent new devices to monitor and evaluate medical performance. Given the apparent 'un-medical' qualities of reporting, it is unsurprising to find that some doctors believed it was primarily devised for non-medical groups. Together these findings go beyond the problems of 'blame' and identify other deep-seated cultural attributes of medicine that inhibit incident reporting.

Reflecting on Allsop and Mulcahy's (1998) analysis of medical attitudes towards complaints, this study reveals not just the cultural barriers to reporting but also the underlying cultural significance of collegiality. On the one hand this serves to maintain the external image of medicine and protect the identity of physicians from unsympathetic criticism. This can be seen in the paradoxical accounts of medicine, which has been simultaneously described as driven by the veneer of invulnerability and perfection (Helmreich and Merritt 2003, Leape 1999), but also culturally accepting the inherent uncertainties, risks and errors of practice (Fox 1975, Rosenthal 1995). There is an apparent divergence, therefore, between how medicine is portrayed and received in the wider society and how doctors themselves understand their work. As such it is not just the fear of blame that inhibits medical reporting but also the desire to protect the symbolic façade of professional competence, and the identity and status of the physicians with the patient.

On the other hand, the rejection of incident reporting also demonstrates the desire to maintain the collegial or 'in-house' control of medical quality issues. By not reporting doctors deny non-professional groups the opportunity to engage in the bureaucratic

surveillance and regulation of medical work, whilst reinforcing the cultural norm that professional learning comes through individual reflection or peer-based practices (Allsop and Mulcahy 1996, Harrison 2002, Rosenthal 1995). It has been well documented how medicine is characterised by notions of 'clinical autonomy' and 'self-regulation' (Freidson 1970) and, despite re-evaluations of these concepts (Evetts 2000), they continue to shape medical culture and practice. Furthermore, this research shows that these professional ideals could also shape attitudes towards incident reporting because, unlike collegial systems, it is regarded as un-medical, managerial and ineffective in dealing with the inevitable errors of medicine. As such medical reporting is discouraged because it is perceived as further extension of managerialism and an erosion of professional status.

These findings suggest that rather than focussing simply on the "blame culture" of health care or medicine, it would be more appropriate to understand how the 'culture of medicine' in general relates to incident reporting. The fear of blame is certainly a barrier to reporting but this could be as much rhetoric as reality, whilst other more deep-seated socio-cultural features of medical professionalism have also been found to inhibit reporting. In consequence establishing a "reporting culture" or even a "safety culture" requires more than removing blame or establishing reporting processes, but requires engaging with the complex culture of medicine. This could include stimulating medical ownership or control in the processes of reporting and enhancing awareness about the function of reporting.

In summary, the qualitative data reveals important facets of medical culture that relate to incident reporting. Although the fear of blame is certainly an influential cultural issue, it was not in itself the only dimension that shaped medical attitudes towards and participation in reporting. As such it may be more appropriate to move beyond the concept of a 'blame culture' and the creation of a 'just culture', and recognise the more complex occupational and professional cultures that relate to reporting.

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