

4 Rehabilitating Blame

Samuel Reis-Dennis

Introduction

Much of the work on medical error and adverse events is forward-looking. It focuses on how to reduce the risk of future errors and how to make hospitals safer for future patients. As a moral philosopher interested in the psychology and ethics of what philosophers have called the "reactive attitudes" (blame, pride, hurt feelings, gratitude, etc.), my interest is different. My project is backward-looking. It asks: what kinds of attitudes should doctors, patients, and families take toward errors that have already occurred, and what kinds of interactions should we encourage between these parties in the wake of harmful mistakes?

It is widely agreed that physicians should disclose professional errors to patients.¹ But difficult ethical questions arise once an error has been disclosed or discovered. What happens next? In this chapter, I argue that, to adequately face and respond to certain kinds of medical mistakes, we should cultivate a culture of blame. The suggestion will strike many as surprising, even scandalous. After all, the current consensus is just the opposite: blame is thought to be corrosive, counter-productive, and even unjust.² It is understood to be an obstacle on the way to improved patient safety practices and a cause of deep distress among providers and patients.³ Consider, for example, a passage from Nancy Berlinger's *After Harm: Medical Error and the Ethics of Forgiveness*:

It is difficult to imagine anyone in contemporary medicine who would argue in favor of the traditional "blame-and-shame" approach to the aftermath of medical error, which holds that mistakes are made by "bad apples" who can be isolated and punished. Yet rooting out the remnants of blaming and shaming attitudes within professional and institutional cultures continues to be a challenge for physicians and others involved in patient-safety efforts. In this, medicine is no different from society in general. It's easier, and perhaps more satisfying psychologically, to pin blame on an individual rather than to do the hard work of facing and addressing systems problems.

(Berlinger 2009, 97)

In vindicating blame as a response to medical error, I will not advocate a return to such a "bad apple" blame culture. I will, however, defend the targeted feeling and expression of angry, resentful, and even vindictive blaming attitudes toward health-care providers who culpably fall short of the standard of care. Only by validating such attitudes in response to such behavior, I claim, can we create a culture that takes victims' feeling resentment seriously as one part of the process of facilitating respect, accountability, and healing.

In the next two sections, I will sketch and respond to some influential, but misguided, arguments against blame as a response to medical error. In doing so, I hope to give the reader a sense of what I mean by "blame," how it differs from shame, and how we might understand the relationship between personal blameworthiness and one's role in an institutional structure. Later, I make the positive case for blame, emphasizing its ability to help us stand up for ourselves and others, thereby facilitating self-respect. In the final section, I raise and respond to what I take to be the most serious objections to a culture of blame in health care and then offer some brief concluding remarks.

Blame and Shame

Some of the resistance to blame in health care stems from a tendency, both in the bioethics literature and in everyday life, to conflate blame and shame.⁴ In vindicating a "blame culture," I mean to defend, as Susan Wolf puts it:

A range [of attitudes] that includes resentment, indignation, guilt, and righteous anger—they are emotional attitudes that involve negative feelings toward a person, arising from the belief or impression that the person has behaved badly toward oneself or to a member (or members) of a community about which one cares and which tend to give rise to or perhaps even include a desire to scold or punish the person for his bad behavior.

(Wolf 2011, 336)

One source of disagreement in the contemporary philosophical literature on blame is the question of whether blame, at its core, is a judgment, or whether the essence of blame is to be found in the feeling and/or expression of "reactive" attitudes, such as anger and resentment. My own position is that this question is somewhat misguided. We use the word "blame" in various contexts to describe a wide range of reactions. In some cases, blaming may involve only a judgment of culpability with no reactive sentiment ("I blame the Secretary of Treasury for the economic downturn."); other times, it seems to involve resentful or angry feelings

("I can't be around Jones. I still blame him for the way he disrespected my mother.").

Here, I do not wade into the debate over the essence of blame. Instead, I have stipulated that I will be focusing on the ethics of a set of emotional blaming attitudes. These attitudes depend upon, but go beyond, judgments of sub-standard conduct. I have chosen to focus on these emotional blaming attitudes for two reasons: First, because they are more difficult to justify, and in greater need of moral vindication, than mere judgments of impropriety. Second, because they seem to lie at the core of the most ethically interesting controversies surrounding blame. After all, even some strong "anti-blame" advocates will no doubt agree that judgments of culpability are sometimes apt and even necessary (for purposes of training and education, for example). What they will not sanction, however, are the angry, resentful, and punitive impulses associated with the kind of "reactive" blaming I am interested in here. These emotional blaming responses are, I think, at the heart of the dispute about the propriety of blame and "blame culture."¹

These blaming attitudes are responses to wrongful harm; they are appropriate reactions only to the violation of a good standard of interpersonal conduct, or to a wrongful frustration of a reasonable expectation. Shame, by contrast, is characteristically a response to the perception of one's own character or self as deficient or sub-standard.² As such, it focuses on the transgressor rather than the transgression, and inspires hiding, isolation, and inwardness. (Consider some classic shame reactions, such as hiding one's head in one's hands or wanting to disappear.)

Unlike shame, blame inspires guilt, which characteristically prompts confession and apology. Blame is an invitation to a kind of moral dialogue: it aims to draw the offender in.³ Shaming, on the other hand, pushes the offender away, sending the message that the offender may only be fully welcomed back into the community when he is a better person. This is why the philosopher Herbert Morris wrote that blame calls for restoration but shame calls for creativity (Morris 1976, 62).

I will return to the connections among blame, guilt, apology, and forgiveness later. For now, I only wish to emphasize the simple point that shaming and blame can, and should, come apart. In the medical context, this means that a blame culture need not be a shame culture. The fact that a clinician has committed a blameworthy mistake does not necessarily mean that he is a bad person, that he should lose his job, that he should be looked down upon or ostracized by his peers, or even that he is a sub-standard doctor. It means that he culpably violated a reasonable standard of behavior and has perhaps harmed a patient as a result.

The conclusion, then, that making a place for blame as a response to medical error would amount to endorsing a "bad apple," "blame-and-shame" approach to the aftermath of medical error would too hasty (Berlinger 2009, 97). Blaming attitudes—even in their angry, resentful,

and vindictive forms—can single out without isolating, aiming to draw wrongdoers in rather than cast them out. And, because they focus on the transgression rather than the transgressor, they are deeply antithetical to the “bad apple” model.⁴

Blame, Control, and Accountability

Even if one accepts that blameworthiness does not imply rottenness, one may still have a lingering sense that blame culture is “bad apple” culture in another sense. The fear is that when we place “the blame” for a mistake on a single individual, we exonerate ourselves. One might suspect that the urge to blame others expresses an objectionable desire to avoid or ignore the reality of our own complicity, or to (mis)understand error and failure as results of human agency, rather than more insidious, systemic factors. One might worry, then, that determinations of blameworthiness would block thorough inquiry, preventing us from addressing root causes.

This objection to blame can seem especially significant when paired with worries about agency (or lack thereof) in institutional contexts. That one cannot be blameworthy for what one cannot control is a widely held moral principle. It would be unjust—even cruel, one might think—to blame someone who had lacked control over her actions.⁵ In fact, I think that there are reasons to be suspicious of this principle,⁶ but I will suppose in this chapter that it is true that control is a necessary condition of blameworthiness. Do clinicians who make mistakes lack the sort of control that would make them proper targets of blame?

Sidney Dekker has suggested that they may for what appear to be two distinct reasons. The first is supposed to follow from the observation that many medical failures are “systems errors” that resist easy attribution to any single agent. Dekker sees the urge to blame as an expression of a human tendency to exaggerate our own agential powers in an effort to maintain an illusion of control. He writes:

Features of people's tools, tasks, and organizational context all constrain control and limit freedom of choice over good or bad outcomes. The ideal of rational, regulative human action is circumscribed by design and operational features. Design things in certain ways and some errors become almost inevitable.

(Dekker 2013, 31)

It is true that we often overestimate the extent to which agents control outcomes, but surely there is room to admit this fact while leaving some space in the picture for human agency. In other contexts (sports teams, orchestras, corporations, academic departments), we are able to distinguish between actions and outcomes attributable to rational agents,

and ones better thought of as products of non-human causes. A trumpet player who arrives to the concert without having practiced his part, for example, is rightly held accountable when he plays poorly. In this respect, medicine is no different from these other arenas. The fact that the causal history of a medical mistake is complex, involving, perhaps, multiple agencies operating under varying degrees of institutional constraint, does not in itself imply that these agents are not morally responsible for their behavior.

Of course, in certain cases, when the constraints are especially severe, responsible agency may fall out of the picture entirely, but not all mistakes and failures occur under such extreme conditions. Indeed, even many actions that express a deeply entrenched institutional culture may be blameworthy. Consider, for example, the thesis, defended by Lucian Leape et al., that disrespectful behavior is common in many health-care institutions and poses a grave threat to patient safety (Leape et al. 2012). Patients who are treated disrespectfully, it seems to me, are right to blame disrespectful practitioners for that mistreatment, especially when the dismissive or degrading behavior results in a harmful error. The fact that such behavior may be normal within a given institutional context is not exculpatory—in fact, blaming, and taking actions that express blame, may be the best way to begin the process of changing such a culture.²¹

Dekker's second reason for pessimism is more general. Medicine and its practitioners are imperfect. Human error, especially under conditions of stress and fatigue, is not something that one could reasonably expect to fully avoid, especially over the course of a long career. Everyone makes mistakes occasionally. This is true, but the fact that failure is part of a normal, even good, medical career does not mean that agents are not blameworthy for some of the mistakes they do make. That one could not reasonably be expected to be perfect over a lifetime does not imply that a patient is not entitled to expect her clinician to operate within the standard of care in each instance. Again, we should resist the urge to hold medicine apart from everyday life. It is not reasonable for two friends to expect to go through life without ever failing to live up to the standards that shape and govern their friendship; nevertheless, when one breaks a promise, forgets an appointment, or otherwise falls short of the reasonable expectations friends have for one another, she is rightly blamed for her failure. The fact that being a perfect friend is nearly impossible does not imply that friends lack the control required for responsibility and blameworthiness when they fall short.

It is significant, I think, that these concerns about control seem most pressing in the context of blame that flows "downhill," from powerful people at the top of social or institutional hierarchies to less powerful blamed agents. The CEO of a large hospital system might, for instance, eagerly pin "the blame" for a botched procedure on a young nurse to convince stakeholders not to worry about more serious underlying problems

that put the nurse in a position to fail. If we understand blame culture to always involve a funneling of angry feelings toward individual agents at the expense of a complete understanding of contextual factors, then we should reject it. But blame culture need not involve such narrow-mindedness. The assumption that it does, has, I think, been unfortunately pervasive in medicine. Well-meaning scholars and practitioners, though rightly emphasizing the power of systems and the need for accountability up the "chain of command," have thrown the baby out with the bath water in embracing the "no blame" model.

Blame, Status, and Self-Respect

Thus far, I have mostly been concerned to relieve some common, but misguided, worries about blame. Now I will make a positive case for it. I have already discussed some ways in which blame can go wrong: when it veers into unwarranted shaming that does not draw the offender back into the moral fold, when it allows the powerful to deflect responsibility onto socially weaker agents, and when it distracts from deeper systemic problems. My goal in this section will be to explain why and how blame works when it works *well*, and what we would gain by rehabilitating it. My central claim is that we should make a place for blame in our toolbox of responses to medical error because it is a social-leveling mechanism allowing victims and their families to communicate a laudable fighting spirit. To get a sense of how it does so, we will need to understand the distinct social role that feelings and expressions of blame play in moral life.¹²

Let us consider the feeling first. Various philosophers have convincingly argued that resentment is a defensive passion, one that arises in response both to personal disrespect and to threats to the moral order.¹³ As Jeffrie Murphy and others have noted, a resentful person cares deeply about how she, and others, are thought of and treated and, as a result of her feeling resentment, is likely to feel motivated to do something about such mistreatment (2005, 19). Feelings of resentment reflect a belief, not only that one has been wronged, but that the wrong cannot stand, that moral order must be restored.¹⁴

Feelings of resentment are most clearly fitting when a moral agent communicates a disrespectful, degrading, or otherwise morally unacceptable message through his behavior. When this kind of wrongdoing is allowed to stand, it changes what I'll call the *de facto* social statuses of both the victim and the wrongdoer, especially when the victim is harmed. Victims become, in some sense, people whom wrongdoers can insult, disrespect, or otherwise mistreat, while wrongdoers become people who stand "above the law."¹⁵

Sometimes, perhaps especially when we read philosophy, it can be tempting to tell ourselves that we all have equal moral worth, that

nothing anyone does can change that, and that we ought not to indulge our fragile egos by caring so much about our *de facto* statuses. In fact, I think *de facto* social standing is worth caring about, too. A certain kind of concern about where one stands in a social or moral hierarchy is a sign of genuine investment in the project relating to others in a way that does not compromise the dignity of the parties. It is a product of the desire to enjoy the kinds of good relationships that call for social and moral equality. When one's *de facto* status is threatened by culpable wrongdoing, it can often be permissible, and even good, to defend oneself.

For purposes of illustration, suppose a patient presents in the emergency room with burns, and the attending physician fails to wash his hands before treating them. As a result, the patient is infected with sepsis and endures a terrifying hospital stay before recovering. As she is preparing to finally leave the hospital, a resident informs her that she suspects the infection was a result of the physician's failure to follow protocol. Through his actions, the physician reveals a disregard, or at the very least a lack of concern, for the patient's safety. His actions reflect objectionable priorities. Making matters worse, the patient trusted this doctor and had the right to expect better treatment.

In cases like this one, blame is well-suited to the task of standing up for oneself and righting status imbalances. To see why, it will be helpful to contrast blame with another reaction one might have to being wronged: disappointment. Disappointment, though not exactly out of place as a response to disrespect and/or wrongdoing, reflects a distinctive understanding of the event and the relationships at stake. This is because disappointment characteristically goes beyond resentment by revealing a kind of despair, signaling re-evaluation or withdrawal. Consider the distinctive pain of knowing you have disappointed a close friend or family member: if the disappointment is justified, you have not only failed to live up to the standards that govern the relationship. Rather, you have failed to be or become the kind of person the wronged party thought you were or could be. These kinds of shortcomings inspire shame instead of, or in addition to, guilt. As a result, they are in general harder to undo than transgressions that would prompt anger, which do not necessarily imply re-evaluation of character or a weakening of the relationship. In fact, in many cases an angry reaction implies the opposite; namely, that the offender, through humbling himself and apologizing, can more or less set things right, or at least start on a path toward forgiveness and reconciliation.

Angry, blaming emotions are distinctive because they signal a willingness to act rather than to withdraw. In anger and blame, we *fight back* in an effort to right the status imbalances that gave rise to our angry feelings. Expressed blame, then, communicates both vulnerability and resolve. To fight for a relationship, rather than reconsidering it or withdrawing from it, can be a sign of trust and investment. Expressing blame,

as opposed to disappointment or sadness, allows us to communicate our faith, or at least hope, that the episode that gave rise to the blame will not force us to reassess or terminate the relationship.

Equally, signaling one's willingness to fight can be an act of bravery, a way to assert or restore one's status, dignity, and self-respect. And because blaming attitudes are fighting attitudes, there is a boldness to anger that sadness and disappointment lack. Anger often triggers anger in return; in expressing it, victims risk potential backlash. But one's willingness to provoke is itself a sign of strength, and demonstrating such courage can facilitate self-respect and the restoration of status.

This analysis helps to explain the significance patients place on apology in their narratives of medical mistakes.¹⁶ I have claimed that blame is a leveling emotion, one that seeks to right social and moral imbalances that arise as a result of wrongful harm. Apology is a humbling act. In saying "I'm sorry," wrongdoers announce that they do not see themselves as above the law, that they understand their victims as worthy of respect and consideration, and that they wish to repair the relationship that their actions altered or jeopardized. In other words, apology is an apt and productive response to one's own blameworthiness. In fact, to fully understand apology, we must seriously face the resentful feelings that help shape its meaning and give it significance.

In good relationships between moral and social equals, all parties are able to safely make justified resentful feelings felt and understood in a way that could lead to apology, forgiveness, and reconciliation. Unfortunately, provider-patient relationships—which are usually characterized by imbalances in status—often fall short of this ideal. The rejection of "blame culture" is both a symptom and a (partial) cause of these power disparities. It is a symptom insofar as people who already feel powerless may reasonably feel afraid to express blame for fear of retribution from their powerful targets. Worse yet, it may not even occur to patients to express such attitudes: absent a context in which being heard and understood appears possible, expressions of blame will seem out of place.

The rejection of blame is a partial cause of these power imbalances as well. Not being held accountable for one's mistakes can entrench feelings of superiority, a sense that one is above the law. In victims, discouraging blame reinforces the impression that there is nothing they can do about being disrespected, that they do not deserve, or at least could never hope to achieve, the sort of status that would make expressions of blame safe and effective. The result is that many patients, especially socially disadvantaged ones, may emerge from their interactions with the health-care system feeling frustrated, alienated, and resigned. Rather than fighting to repair and continue relationships with providers as moral equals, they may withdraw in disappointment and despair.¹⁷

Avoiding Blame's Pitfalls

Until this point, I have mostly focused on the features of blame that allow victims to protect their dignity by expressing a willingness to stand up for themselves. But what about the effects of blame on practitioners who make mistakes? Many providers who act negligently are racked with guilt and shame over their mistakes, and one might reasonably wonder whether an institutional culture that made space for blame, and by extension, encouraged feelings of guilt, would be professionally and personally devastating. The first thing to say in response to this worry is that feeling guilty in response to one's culpable mistakes is good. It is a psychologically normal, and morally laudable, reaction for a person invested in a lifelong project of healing. Of course, excessive guilt can be pathological, but a culture that aimed to eliminate guilt, or even tried to minimize it, would be artificial and inhuman.

How, then, can we embrace guilt without allowing it to devolve into pathological self-loathing? The key, I think, is to provide a productive outlet for guilt so that it motivates efforts to seek forgiveness and reconciliation rather than solitude. The process that provides such an outlet, that allows wrongdoers to move from guilt to forgiveness, belongs to the logic of blame. In fact, I suspect that it is in large part the *rejection* of the ethics of blame that leads practitioners to internalize their mistakes and misdeeds as crushing, shameful traumas. The point may strike some as counterintuitive, but the thought is an extension of the earlier observation that guilt and blame (as opposed to shame and shaming) characteristically draw offenders *in*, inviting them to participate in moral dialogue. Blame culture—with its almost ritual procession from anger to confession to apology to forgiveness to reconciliation—can provide both victims and authors of error a process through which to heal and move forward. Consider the following passage from David Hilfiker's classic piece "Facing our Mistakes":

The drastic consequences of our mistakes, the repeated opportunities to make them, the uncertainty about our own culpability when results are poor, and the medical and societal denial that mistakes must happen all result in an intolerable paradox for the physician. We see the horror of our own mistakes, yet we are given no permission to deal with their enormous emotional impact; instead, we are forced to continue the routine of repeatedly making decisions, any one of which could lead us back into the same pit. . . . The only real answer for guilt is spiritual confession, restitution, and absolution. Yet within the structure of modern medicine, there is simply no place for this spiritual healing. . . . It simply doesn't fit into the physician-patient relationship.

(1984, 21)

My suggestion is that a blame culture is uniquely well-suited to provide the sort of structure that would make such redemptive healing possible. Practitioners need to be able to move on, to be resilient, and to forgive themselves in the wake of costly mistakes. Blame offers us a logic within which this resilience could be tasteful, and self-forgiveness could be earned.

Still, one might wonder whether expressions of blame are truly the best way to register that one has been hurt or disrespected. We all know, after all, that blame can often spiral out of control, turning into bullying and abuse. It can also provoke backlash and retaliation, straining relationships and driving people apart. This is a serious and important objection to making room for blame in health care, but I do not think it is fatal. It is no accident that feeling the force of blame is jarring and unpleasant. In fact, in order to fully understand the power of blame, we must acknowledge (and even endorse) its connection to action. The fact that blame can so often be unsettling, loud, and even threatening, is what allows it to do its characteristic work, both of prompting offenders to rethink their behavior and apologize, and of fostering self-respect in victims. I am not claiming, however, all blaming reactions are, or should be, scary and threatening (though in some cases they may be). And, crucially, I am not defending blame that is bullying or abusive. Rather, I have mostly been trying to explain why blame works when it works well, and to give the reader a sense of what we would gain by making some space for it in health care.

Full appreciation of blame's dangers does, however, underscore the need for virtues and rules that would help patients and providers feel, express, and receive blame well. The task of developing the virtues and rules necessary to *prevent* blaming interactions from degenerating into corrosive chaos, is both philosophical and practical: Philosophically, we must explicate the virtuous traits of character and the appropriate normative constraints; practically, we must do the everyday work of cultivation and enforcement.

At this point, some readers may suspect that such institutional overhaul is impossible, or at least highly unlikely. Are not hospital administrators and risk managers likely to reject anything even involving the word "blame" out of sheer instinct?¹⁴ Is it not likely that doctors will hide their mistakes for fear of being blamed?¹⁵ Where would we even begin the task of cultivating the necessary virtues and establishing the necessary institutional rules? Perhaps these obstacles will ultimately prove insurmountable, but such pessimism and cynicism is no place to begin. Although I do not wish to gloss over the difficulty of cultivating the virtues of character that will allow us to blame well (at the right times, in the right ways, toward the right people) and be good recipients of blame (willing to acknowledge our blameworthiness and apologize without lapsing into defensiveness or self-hatred), my hope is that these challenges will

be overwhelming. Cultivation of virtue is famously difficult, requiring instruction, perseverance, and luck. But we are not totally in the dark: as we aspire to make sweeping changes, we may draw from a wealth of successful cases of interpersonal blame outside of health care as models for a more general practice.²⁰ In establishing such a practice, we would acknowledge and accept the role blame can play in constructive responsibility exchanges—prompting and facilitating honest and sensitive inter- and socially and that actively seek to mend them.

Specifying exactly what it would mean to give and receive blame well in concrete cases, and offering a more complete outline of a good blaming practice, are important tasks that lie outside the scope of this chapter. The details of both will vary depending on the cases and institutions in question. In some instances, an ethics committee might have a role to play in determining blameworthiness and in moderating a successful blaming interaction; in others, the ideal response to a culpable error could involve respected colleagues encouraging a physician who had behaved negligently to listen to his patient's justified complaints and apologize.

This sort of practical application, though, is not best left solely in the hands of philosophers. I suspect that the most successful blaming practices would be developed locally through a deliberative process that allowed physicians, nurses, administrators, legal experts, patients, and scholars from a wide range of disciplinary backgrounds to express their needs, reservations, and aspirations. My goal in this chapter has not been to offer a comprehensive blueprint for good blaming practices. While I have tried to explain the need for such practices and lay some conceptual groundwork for them, I do not pretend to know exactly how blame could be most justly and productively integrated into the institutional fabrics of specific health-care institutions. This is work that I envision scholars and stakeholders taking up together.

I do hope to have shown that, though daunting, the task of making space for blame in health care is worthy of our best efforts. Rehabilitating blame would help us to bring provider-patient interactions into line with an ideal of human communication that many of us aspire to in our best and most significant personal relationships, and it would give those who have suffered as a result of culpable medical error the opportunity to fight for respect and affirm their dignity with authenticity and force.

Notes

1. See, for example, Tello (2016), Fryer-Edwards (2016), and Berlinger (2009).
2. For two examples of anti-blame sentiment, see: Khatri, Brown, and Hicks (2009), and Bell et al. (2011).
3. One notable exception is the work of Edmund Pellegrino, who, in persuasively arguing that even actors within large systems can be personally accountable for their failures, writes that a blame-free approach opens the

- door for "complacency and dulling of the moral sensibilities" (88) and that a "no-blame system could . . . often be a travesty of social and communitarian justice" (89). See: Pellegrino (2004). In this chapter, I extend Pellegrino's arguments by defending a blame culture that would promote and facilitate the kind of accountability he has in mind.
4. Berlinger in *After Harm*, for instance, often deals with blame and shame together. For another example, see Liang (2004).
 5. For readers interested in the philosophical debate about blame's nature, the essays collected in Coates and Tognazzini's *Blame* are a good place to start. See: Coates and Tognazzini (2013).
 6. My thinking about shame has been shaped by Herbert Morris's "Guilt and Shame." See: Morris (1976).
 7. For an influential defense of a "conversational" model of blame, see McKenna (2013).
 8. This is not to say that some sorts of errors do not reveal their authors to be "bad apples." Some medical failures express contempt for patient safety, shocking arrogance, or other shameful vices.
 9. Moral luck seems to put pressure on such a principle. See Chapter 2: "Medical Error and Moral Luck" by Allhoff.
 10. For arguments against a control condition on blameworthy agency, see Adams (1985) and Smith (2008).
 11. I explain why this may be the case in the next section.
 12. This section, particularly my discussion of the differences between blame and disappointment, draws heavily from Reis-Dennis (2018b). In that paper, which does not focus on health care, I explore the psychology and ethics of angry feelings and the scary outbursts that express them, and I respond to some prominent anti-anger arguments in the contemporary philosophical literature.
 13. For more on investment in the moral order, see chapter two of Murphy (2005).
 14. Murphy, for example, writes, "I am, in short, suggesting that the primary value defended by the passion of resentment is *self-respect*, that proper self-respect is essentially tied to the passion of resentment, and that a person who does not resent moral injuries done to him . . . is almost necessarily a person lacking in self-respect" Murphy (1988, 16).
 15. As Murphy (1988, 28) puts the point: "Wrongdoers attempt (sometimes successfully) to degrade or insult us; to bring us low; to say 'I am on high while you are down there below.' As a result, we in a real sense *lose face* when done a moral injury—one reason why easy forgiveness tends to compromise self-esteem. But our moral relations provide a ritual whereby the wrongdoer can symbolically bring himself low (or raise us up—I am not sure which metaphor best captures the point)—in other words, the humbling ritual of apology, the language of which is often that of *begging for forgiveness*. The posture of begging is not very exalted, of course, and thus some symbolic equality—necessary if forgiveness is to proceed consistently with self-respect—is now present."
 16. See chapter three of Berlinger's *After Harm* for examples of such narratives.
 17. For research on the pervasiveness of lack of trust in health care, as well as its implications for patient health, see: Armstrong et al. (2006).
 18. I have not mentioned the legal implications of allowing blame back into medicine, though the ways in which blame, apology, and the law interact will obviously be central to the success of a real-life blaming practice. My concern in this chapter has been to establish a moral basis for the rehabilitation of blame rather than to address these important practical legal questions.

19. This is an empirical question that would be difficult, perhaps impossible, to answer without first successfully establishing the kind of "blame culture" I have suggested here. For more on the tension between backward-looking respect for victims and forward-looking safety considerations, especially as it relates to the ambitions of the "Just Culture" movement, see Reis-Dennis (2018a).
20. I have in mind everyday instances of blame between friends and family members. Imagine, for example, that a roommate repeatedly fails to do his share of communal chores. His roommates' forceful but respectful expressions of blame could both help them stand up for themselves and prompt the offender to think harder about the impact of his actions on others. Blame, from patients, families, and even colleagues, could function similarly in health care, at least in response to certain kinds of transgressions.

Works Cited

- Adams, R. 1985. "Involuntary Sins." *The Philosophical Review* 94 (1): 3–31.
- Armstrong, Katrina, Abigail Rose, Nikki Peters, Judith Long, Suzanne McMurry, and Judy Shea. 2006. "Distrust of the Health Care System and Self-Reported Health in the United States." *Journal of General Internal Medicine* 21 (4): 292–297.
- Bell, Sigall, Tom Delbanco, Lisa Anderson-Shaw, Timothy McDonald, Thomas Gallagher. 2011. "Accountability for Medical Error: Moving Beyond Blame to Advocacy." *Chest* 140 (2): 519–526.
- Berlinger, Nancy. 2008. "Medical Error." In Mary Crowley (ed.), *From Birth to Death and Bench to Clinic: The Hastings Center Bioethics Briefing Book for Journalists, Policymakers, and Campaigns*. Garrison, NY: The Hastings Center: 97–100.
- Berlinger, Nancy. 2009. *After Harm: Medical Error and the Ethics of Forgiveness*. Baltimore, MD: Johns Hopkins University Press.
- Coates, D. Justin, and Neal A. Tognazzini (eds.). 2013. *Blame*. New York: Oxford University Press.
- Dekker, Sidney. 2013. *Second Victims: Error, Guilt, Trauma, and Resilience*. Boca Raton, FL: CRC Press.
- Fryer-Edwards, Kelly. 2016. "Tough Talk: Medical Error." In *Tough Talk: A Toolbox for Medical Educators*. Retrieved from <https://depts.washington.edu/toolbox/toc.html>.
- Hilfiker, David. 1984. "Facing Our Mistakes." *New England Journal of Medicine* 310: 118–122.
- Khatri, Naresh, Gordon Brown, and Lanis Hicks. 2009. "From a Blame Culture to a Just Culture in Health Care." *Health Care Management Review* 34 (4): 312–322.
- Leape, Lucian, Miles Shore, Jules Dienstag, Robert Mayes, Susan Edgman-Levitan, Gregg Meyer, and Gerald Healy. 2012. "Perspective: A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians." *Academic Medicine* 87 (7): 845–852.
- Liang, Bryan. 2004. "Error Disclosure for Quality Improvement: Authenticating a Team of Patients and Providers to Promote Patient Safety." In Virginia Sharpe (ed.), *Accountability: Patient Safety and Policy Reform*. Washington, DC: Georgetown University Press: 59–82.

- McKenna, Michael. 2013. "Directed Blame and Conversation." In D. Justin Coates and Neal Tognazzini (eds.), *Blame*. New York: Oxford University Press: 119-140.
- Morris, Herbert. 1976. *On Guilt and Innocence*. Berkeley, CA: University of California Press.
- Murphy, Jeffrie. 1998. "Forgiveness and Resentment." In Jean Hampton and Jeffrie Murphy, *Forgiveness and Mercy*. Cambridge: Cambridge University Press: 14-34.
- Murphy, Jeffrie. 2005. *Getting Even: Forgiveness and Its Limits*. Oxford: Oxford University Press.
- Pellegrino, Edmund. 2004. "Prevention of Medical Error: Where Professional and Organizational Ethics Meet." In Virginia Sharpe (ed.), *Accountability: Patient Safety and Policy Reform*. Washington, DC: Georgetown University Press: 83-98.
- Reis-Dennis, Samuel. 2018a. "What 'Just Culture' Doesn't Understand About Just Punishment." *Journal of Medical Ethics* 44: 739-742.
- Reis-Dennis, Samuel. 2018b. "Anger: Scary Good." *Australasian Journal of Philosophy*, forthcoming. Available online.
- Smith, Angela. 2008. "Control, Responsibility, and Moral Assessment." *Philosophical Studies* 138 (3): 367-392.
- Tello, Monique. 2016. "Medical Errors: Honesty is the Best Policy." *Harvard Health Blog*. Retrieved from www.health.harvard.edu/blog/medical-errors-honesty-is-the-best-policy-2016100310405.
- Wolf, Susan. 2011. "Blame, Italian Style." In R. Jay Wallace, Rahul Kumar and Samuel Freeman (eds.), *Reasons and Recognition*. New York: Oxford University Press: 332-347.